INVESTIGATION OF THE NATURE OF FORMAL AND INFORMAL SOCIAL SUPPORT FOR YOUNG MOTHERS IN SALFORD, AND ITS IMPACT UPON THEIR EXPERIENCE OF SOCIAL EXCLUSION

ANGELA MCLEOD

School of Social Work, Psychology and Public Health, University of Salford, Salford, UK

Submitted in Partial Fulfilment of the Requirements of the University of Salford for the Degree of Master of Philosophy, July 2011

Table of Contents

List of Tables

List of Figures

Author's Declaration

I declare that the work in this dissertation was carried out in accordance with the Regulations of the University of Salford. The work is original except where indicated by reference in the text and no part of the dissertation has been submitted for any other degree.

Any views expressed in the dissertation are those of the author and in no way represent those of the University of Salford.

The dissertation has not been presented to any other University for examination either in the United Kingdom or overseas.

SIGNED..... DATE.....

Abstract

Teenage pregnancy has been identified as a socially excluding experience. UK policy initiatives have sought to reduce the prevalence of teenage pregnancy and also to provide social support to young mothers. The conceptual and political underpinnings of the UK approach have been critically examined in terms of how they aim to tackle social inclusion. The nature of both formal and informal social support for young mothers during and after pregnancy is a complex area for study. There is little available evidence on how support for teenage mothers can constitute social capital. The potential impact of this support on social exclusion is unknown.The aim of the study is to examine teenage mothers' experiences of social support and social capital.

A qualitative approach was taken to data collection based around an established model of social support. Semi-structured interviews were undertaken with 10 employees from voluntary and statutory services with specialist young parenting provision. In-depth semi-structured interviews were undertaken with 18 young mothers during pregnancy, and from a new sample of 10 young mothers following the birth of their child. The study took place in a deprived inner city in the UK.

Most support was provided from mothers own mothers but these relationships were often fragile, and networks tenuous. Wider support networks are missing within their social environment. Supportive relationships often became strained through over-dependence and relationships are sometimes detrimental to establishing social inclusion. Support that young mothers did receive was useful in helping them cope on a day to day level but did not constitute a form of social capital (e.g. bridging capital) that could provide opportunities for social inclusion.

Policy initiatives focussed on increasing social inclusion through employment and moral integration may have contributed to the problematisation of young motherhood. Providers could do more to address the real problems of deprivation. A new policy direction in the UK could not only facilitate this

change but also could go some way to promoting the currently under-valued role of young mothers in society.

Chapter 1 – Thesis overview

The transition to motherhood can be unpredictable, stressful and challenging for the mother's self-confidence, irrespective of age, and many mothers feel ill prepared for motherhood. This situation may be exacerbated further in teenage mothers, particularly when they are simultaneously facing long-term social and economic disadvantage (McVeigh and Smith, 2000).

The possibility of becoming a teenage mother is almost ten times higher for a girl in social class V (unskilled manual) than in social class I (professional). Teenage women who live in Local Authority or social housing are three times more likely than their peers living in owner occupied housing to become pregnant. Teenage parents are more likely than their peers to live in poverty and unemployment with little opportunity to change this situation due to a lack of education, childcare and encouragement (SEU, 1999).

Teenage pregnancy has been a health and social care priority nationally within the UK since 1999, when the Social Exclusion Unit (SEU) launched the Teenage Pregnancy Strategy (TPS) (SEU, 1999). The TPS relates only to England, rather than the UK as a whole. The teenage pregnancy rate has changed little during the 1990s in the UK, whereas it has fallen in most other countries within Western Europe (SEU, 1999). In 2004 the conception rate for women aged 15-17 was 57 per 1000, and for women aged 13-15 years it was 12.1 (ONS, 2007). Statistics show that the government target of halving teenage conceptions by 2010 was unlikely to be met, as conceptions among under 16 year olds increased by 1% between 2002 and 2003 (ONS, 2005). Teenage pregnancy is considered a public health problem in western societies because of its association with social and economic problems. However, these socio-economic problems are to a large extent antecedents rather than consequences of teenage motherhood (Jonge, 2001).

Many maternal and social factors can affect the way women adapt to the role of motherhood. Strong social support networks can positively influence adaptation to the new role. The support a new mother receives from those around her is perhaps one of the most important factors influencing her level of well being (McVeigh and Smith, 2000). Social support has been found to be a significant factor in outcome in teenage pregnancy in terms of infant birth weight and psychological distress and depression in the mother (McVeigh and Smith, 2000). An individual's socio-economic background was found to impact on the social support and outcomes for mother and baby (Turner et al, 1990).

The study aims and objectives are developed from a wider research question that seeks to examine teenage mothers' experiences of social support and social capital with particular reference to New Labour's emphasis on the TPS as a means to tackling social exclusion.

Aim: To understand the impact of social support networks in the lives of young mothers

Objectives:

- To describe the nature and function of teenage mother' support networks both during and after birth
- To explore the role that these networks play in constituting social capital and in providing an opportunity for overcoming social inclusion
- To evaluate the impact of the TPS in supporting young mothers and promoting social inclusion

The study will draw on two separate sources of data. Firstly the study will draw on data collected through interviews conducted with staff working in a range of teenage pregnancy services. Secondly, the study will draw on in depth interviews with young mothers about their experiences of social support available to them.

Chapter 2 – Teenage pregnancy: what is the problem?

The following chapters present a range of theoretical and empirical literature on early motherhood, social support, social capital and social exclusion as well as government policy that is relevant to the context of the study. This literature helps to set the scene and explain the relevance of the research in terms of introducing the importance of social networks and social capital in young mothers' lives, introducing the government's approach to addressing teenage pregnancy, and how these concepts relate to the literature around social exclusion.

2.1 Search strategy

The following databases were searched using the following key words in various combinations (table 1):

Table 1 Literature search strategy

Databases Searched	Search Terms
EBM Reviews (Cochrane Database of Systematic Reviews), CINAHL (Cumulative Index to Nursing and Allied Health Literature), EMBASE, OVID Medline, PsycINFO, A SSIA (Applied Social Sciences Index and Abstracts), IBSS (International Bibliography of the Social Sciences).	"Young motherhood" "Early motherhood" "Teenage pregnancy" "Teenage mother" "Teenage parents" "Motherhood" "Social support" "Social support services" "Formal support services" "Mapping services" "Support networks" "Social exclusion" "Social capital"

The search was restricted to English language texts only. Unpublished studies, abstracts and dissertation theses were excluded. In addition to literature found in databases, a large number of local and national policy documents and texts

included in the literature review. These were identified using snowballing techniques by searching through the reference lists of journal articles.

Given the amount of information on the topic some form of organisation of the literature was essential. Hart (1998) describes in detail the importance of mapping the ideas collected from a literature review. Therefore following the initial literature search, I began by classifying the data according to its content. As stated by Hart (1998) without the use of classification, large amounts of information could not be processed in a way that is systematic and progressive. Classification of the literature involved sorting out and organising it into categories and labelling them, with subheadings within each category. For example this included a wide range of papers relating to the topic of 'social support', subheadings within this included qualitative, quantitative methods, outcomes, formal, or informal support etc.

2.2 Trends in teenage pregnancy

There are approximately 90,000 teenage conceptions a year in England resulting in 56,000 live births, which means approximately 60% of young women decide to continue with their pregnancy. Approximately 7,700 (14%) of these conceptions are to women aged under 16. This rate is higher than in any other Western European country. The UK teenage birth rate is, for example, six times that in the Netherlands (SEU, 1999). Salford, in Greater Manchester, is identified in the TPS as having an under-18 conception rate in the highest 10% of all local authority districts nationally (Children's Services Scrutiny Committee, 2007). Throughout most of Western Europe, the teenage birth rate fell during the 1970s, 1980's and 1990's, but the UK rate has stayed virtually the same since the early 1980's.

Research in the UK and other countries shows that young people with a history of disadvantage are at a significantly greater risk of becoming parents in their teens (Harden et al, 2006). One study revealed that the risk of becoming

teenage mothers is almost ten times higher for women from families in social class V (unskilled manual) compared with those in social class I (professional). Similarly women living in social housing are three times more likely to be teenage mothers than those living in owner occupied housing (Botting et al, 1998).

Educational attainment also appears to be an important factor; one survey of teenage mothers found that over 40% had no qualifications, compared with the national average of 6.6% (Harden et al, 2006, Croydon Community Trust, 1994). Another study revealed that of a sample of teenage women excluded from school, 14% became pregnant during the period of exclusion. Amongst women who are post age 16, those who are not in education, training, or employment it was found that half became pregnant, compared with 4% amongst women who were participating in education, training or employment (Byner and Parsons, 1999).

Bonnell et al (2003) found that different dimensions of young people's social exclusion may affect the risk of teenage pregnancy in different ways. In particular they found that alienation from education and the dislike of school to be an important factor of exclusion in leading to an increased risk of becoming pregnant. Similarly in a follow up, longitudinal study, Bonnell et al (2005) concluded that attitude to school was significantly associated with protected and unprotected first sex. Dislike of school was associated with subsequent increased risk of teenage pregnancy.

In addition to this evidence, other risk factors include sexual abuse, mental health problems and crime, in terms of being in trouble with the police. Many young people will experience a number of these risk factors and therefore have a higher chance of becoming a teenage mother. A project run by Barnardo's for young parents in the North West reported that of the young women involved, 40% had been in care, 70% had lived with family breakdown, 40% were the children of

teenage mothers, and all of them had grown up in poverty, had low educational attainment and a history of not attending school (SEU, 1999).

The multiple risk factors associated with teenage pregnancy have led to a geographical concentration of teenage pregnancy, whereby the poorest areas in England have teenage conception and birth rates up to six times higher than the most affluent areas (Smith, 1993). Salford falls within the highest 10% for under 18 conceptions of all the local authority districts in England in 2005 (Children's Services Scrutiny Committee, 2007).

In Salford, teenage pregnancy rates have been higher than those for the rest of England. Salford remains higher than both national and regional averages and was not on target to achieve the 50% reduction in teenage conceptions by 2010 (table 2 and 3) (Children's Services Scrutiny Committee, 2007).

Table 2 Under 18 conception data in Salford

Under 18 conception data (year)	No. of under 18 conceptions	% of conceptions leading to abortion	Conception rate per 1000 young women aged 15-17	% increase (+)/ decrease (-) in rate since 1998
(Baseline) 1998	250	26.4	61.5	N/A
1999	252	36.7	62.1	1.0
2000	219	40.2	53.5	-12.9
2001	236	36.4	56.7	-7.8
2002	216	36.1	52.6	-14.4
2003	238	40.8	58.2	-5.3
2004	232	44.0	57.0	-7.3
2005	254	39.4	60.6	-1.4
Target 2010	125	N/A	30.75	-50

Table 3 Under 16 conception data in Salford

Under 16 conception data (year)	No. of under 16 conceptions	Conception rate per 1000 young women aged 13-15	% increase (+)/ decrease (-) in rate since 1998
(Baseline) 1998	48	11.6	N/A
1999	44	10.5	-9.5
2000	46	11.2	-3.4
2001	40	9.7	-16.3
2002	37	9.1	-21.6
2003	42	10.1	-12.9
2004	51	12.1	+4.3

Source: Children's Services Scrutiny Committee, 2007, Teenage Pregnancy in Salford: A review of the provision of sex and relationships education within Salford, Salford City Council, p.5

Teenage pregnancy 'hotspot areas' have been defined by the government as being areas of wards with conception rates of 60 or more conceptions per 1000 young women aged 15-17. Whilst some local authority areas may have one or two hotspot wards, Salford has 11 out of its 20 wards identified as hotspot areas, which highlights the breadth of the issues within Salford (Children's Services Scrutiny Committee, 2007).

It is recognised within the Teenage Pregnancy (TP) strategy that there is no biological reason why a teenage pregnancy should not have a good outcome. However a study by Botting (1998) found that teenage mothers tend to have pregnancies that are managed less well, due to their circumstances. For example, teenagers are more likely to present to their GP much later in the pregnancy, and teenage mothers are most likely, of all age groups, to smoke during pregnancy (Botting, 1998). It was found that for many, any kind of conventional ante-natal planning was impossible due to the problems of family conflict, change of care or fostering arrangement, relationship stress or breakdown, and problems with education, housing and money (Wellings et al, 1996).

Teenage mothers are 25% more likely to give birth to a low-birth weight baby (Botting, 1998). A 60% higher infant mortality rate in seen in babies of teenage mothers compared to that of older mothers (Botting, 1998). Teenage mothers are only half as likely to breastfeed their babies compared to older mothers (Foster et al, 1997). Other adverse health outcomes included a higher rate of childhood accidents. In addition, postnatal depression is more common amongst teenage mothers. Forty percent of teenage mothers suffer from depression within a year of giving birth, compared with only 20% of older mothers (Wilson, 1995). Teenage mothers are twice as likely (8% v 4%) to perceive themselves as being in poor health compared with women who remain childless in their teens (Wellings et al, 1996). Individuals report a range of stresses including conflict with their own parents, stress of child care on relationships, problems budgeting, going short of food to feed the child, and feelings of stigmatisation by others. However much of the evidence relating to poor health outcomes for young mothers and their babies is contested by writers who suggest that many of these differences can be accounted for by other factors associated with living in poor socio-economic conditions, and factors such as smoking (Smith and Pell, 2001; Ermisch and Pevalin, 2003; Duncan, 2007; Phoenix, 1993).

For many young mothers a stressful experience of early motherhood is compounded by relationship breakdown. Relationship breakdown is more common in teenage parents than in their older parents. Ninety per cent of teenage mothers have their babies outside of marriage, and relationships that are started in the teenage years have at least a 50% chance of breaking down (Allen and Bourke-Dowling, 1998). One study found that around half of teenage mothers were still in a relationship with the father of the baby a year after the baby's birth. The rest were usually single and without a steady partner (Allen and Bourke-Dowling, 1998). One study followed a group of 174 teenage mothers over 15 years. This study found that only 20% of the fathers were still in touch at the end of the study period (Birch, 1998).

Teenage parents usually live on low incomes. Ninety per cent of teenage mothers receive Income Support (SEU, 1999). Teenage parents are more likely to become trapped living on benefits for long periods of time. A study by Davies et al (1996) found that of a sample of young mothers giving birth in the previous three years, only 11% were in paid employment.

The Teenage Pregnancy Unit found that teenage parents were likely to be housed in poor accommodation on large estates often away from family and friends or other sources of support. Teenage parents were six times more likely as other households to live in areas dominated by local authority housing (Botting et al, 1998). Seven out of ten 15 and 16 year old mothers, and around half of 17 and 18 year olds stay at home. The rest tend to live in care or social housing (HEA, 1998). Teenagers are more likely to have to move house during pregnancy; one study showed that 17% of teenage mothers moved three or more times during pregnancy or after birth, they often lived in poor housing, and nearly a third were living alone with their baby a year after birth (Allen and Bourke-Dowling, 1998). One third of young mothers under 20 were living in social housing a year after the birth of the baby, and a further third were on the waiting list (Allen et al, 1998). For many young mothers, a flat of their own with a young child is an isolating experience, when they are already isolated from their peers by being a parent (Speak et al, 1995). In addition a study has shown that homelessness is twice as likely by the age of 33 for teenage mothers, as for older mothers (Kiernan, 1995).

In view of the negative outcomes associated with teenage pregnancy, young parenthood has been viewed as both a consequence and cause of poverty and disadvantage. Ermisch and Pevalin (2003) argue that teenage parents are in fact no worse off than other similar aged young people living in similar areas. Rather than teenage parenthood per se influencing their outcomes, it is suggested that a background of poverty and disadvantage is of greater significance. Ermisch and Pevalin's (2003) study differs from the government's

primarily negative social construction of pregnancy and its preventative focus on teenage conceptions. By contrast it asserts that young people can make positive decisions to become parents with minimal ill effects over the longer term. Although there is a large amount of quantitative, macro-level evidence supporting the relationship between teenage pregnancy and poverty and disadvantage, less is known about *how* this relationship exists (Ermisch and Pevalin, 2003).

Similarly Duncan (2007) argues that there is a problem with the 'official' view of teenage pregnancy, as the research evidence simply does not support it. Duncan suggests that teenage pregnancy may actually be more of an opportunity than a catastrophe. Duncan (2007) explored the literature surrounding outcomes for young mothers and asserts that there are major problems with the consistency and comparability of studies. For example studies do not compare like with like when comparing teen mothers with all mothers, rather than those of similar age and background. Statistical analysis is often not controlled for selection effects. Therefore, becoming a young mother may not cause the poor outcomes in terms of employment, income and education, instead social disadvantage may 'select' particular young women to become teenage parents and this disadvantage continues post pregnancy.

British studies that have attempted to control for selection effects by comparing young women who miscarry with those who go on give birth as teenagers found that early motherhood has little impact upon qualification, employment or earnings by the age of 30 (Duncan, 2007). Similarly Phoenix (1991) found that most young mothers had already performed quite badly in the education system before becoming pregnant, and that deferring pregnancy would have made very little difference. Instead motherhood was something of a turning point which motivated young mothers to access education, training and employment. Duncan asserts that rather than focussing on the 'low expectations' explanation for teenage pregnancy, which would at least point towards tackling social disadvantage, the government focuses on 'ignorance' as an explanation and a

lack of understanding of how to avoid becoming pregnant and the implication of early motherhood. The focus tends to stress individual behaviour and motivations, rather than the structural influences on behaviour, such as the circumstances in which the young person lives. This is explored in more detail below.

2.3 The Government's response to the problem of teenage pregnancy

The government's TPS suggests that the key reason as to why the rates of teenage conceptions are so high in the UK is due to low expectation (SEU, 1999). The strategy describes a situation whereby young people living in poverty and disadvantage have poor expectations of education and the job market. Therefore, young people see no prospect of a job in the future and feel it is inevitable that they will end up living on benefits. The government summarised this as "they (young people) see no reason not to get pregnant." In addition to this, the strategy outlines 'ignorance' in terms of knowledge of contraception, and 'mixed messages' about sex from the adult world as the other two reasons for the high teenage conception rate in the UK.

Current government policy outlined in the TPS, aims firstly to halve the conception rate of under 18s and set a downward trend in the rate of under 16s by 2010 and, secondly, to achieve a reduction in the risk of long term social exclusion of teenage parents and their children (SEU, 1999). The concept of social exclusion is concerned with structures and processes in society that inhibit certain groups of people from participating fully in normal relationships and activities that are available to the majority of people. These could be economic, social, cultural or political activities which affect quality of life, and the cohesion of society as a whole.

Lawlor et al (2001) argue that the second of these goals, a reduction in social exclusion, is the appropriate public health aim, and yet most action is geared towards the first. This point of view is based on the argument that teenage

pregnancy is not a public health problem; the cumulative effect of social and economic exclusion on the health of the mothers and their babies, whatever their age, is (Lawlor et al, 2001).

The previous UK Government had significantly raised the political profile of teenage sexual behaviour. Teenage sexual health was prioritised by the New Labour government in the White Paper 'Our Healthier Nation' (DoH, 1998). This was followed by the Social Exclusions Unit's report 'Teenage Pregnancy' (SEU, 1999). Since then a national strategy and campaign have been launched. The Teenage Pregnancy Unit established a range of new initiatives including local coordinators, new guidance on sex education in schools, and new support packages for young parents (Hoggart, 2003). The strategy presents a ten-year programme of national and local initiatives to tackle the problem of teenage pregnancy. Initiatives fall into four categories outlined in the table below (table 4):

Table 4 Summary of national teenage pregnancy initiatives

Category	Description
National campaign	A national media campaign to target young people and parents with the facts about teenage pregnancy and parenthood with advice about to how to deal with the pressures to have sex
Joined-up action	A new task force of Ministers, led by the Department of Health to ensure that achieving a reduction in teenage parenthood rates remains a priority for government. In addition to this an independent national advisory group on teenage pregnancy will be set up to advise Government and monitor progress. At a local level each area will have an identified local co-ordinator to pull together local services that have a role in preventing teenage pregnancy and supporting young parents.
Improved prevention	This area of the strategy includes a range of initiatives such as new guidance for schools on sex and relationships education, additional training for teachers, new health service standards for effective contraceptive advice and treatment for young people, a national help line for teenagers on sexual health issues, targeted at young people in Care or in Young Offenders Institutes with sexual health and relationship education, amongst other initiatives.
Improved support	This area of the strategy includes better local co-ordination of services so that pregnant teenagers get advice and support and stop them from falling through the gaps between services, mothers under 16 will be required to finish their education, and will be given help with childcare to ensure this, additional support for young mothers on benefit to find a job, new support packages for young parents to help them with housing, health, parenting skills, education and childcare, the Child Support Agency (CSA) will target fathers of children of under 18 year old mothers for early support action.

2.4 Introducing the problematisation of teenage pregnancy

A focus on the prevention of teenage pregnancy suggesting that it is a 'problem' is implicit in the strategy. There has been much critique of the government's approach to tackling the issue of teenage pregnancy through the prevention of unplanned pregnancies, rather than providing more support to young mothers (Kidger, 2004, Duncan, 2007, Arai, 2009). Other recent policy initiatives include Every Child Matters (DfES, 2003), which aims to reduce the number of children who become teenage parents. In addition, the White Paper, Choosing Health:

Making Healthy Choices Easier (DH, 2004) states that there will be an investment of £300 million to help achieve the goal of reducing teenage conceptions. Whereas little acknowledgement is made of supporting young parents.

The TPS states that 'in practice the first conscious decision that many teenagers make about their pregnancy is whether to have an abortion' (SEU, 1999, p.28). However, parenthood may be the preferred option for many teenagers (Duncan, 2007). The policy emphasis on prevention of pregnancies lends weight to the claim that the UK has an overwhelmingly negative social construction of teenage motherhood (Phoenix, 1993). In this way, teenage mothers are viewed as both 'at risk' in society and as a 'risk to society' (Mitchell and Green, 2002).

The current policy on unplanned teenage pregnancy suggests that teenagers only become pregnant due to failed contraception or a lack of knowledge/poor contraception negotiation skills (Duncan, 2007). There is growing evidence to suggest that some teenager pregnancies have elements of planning (Duncan, 2007), which challenges the stereotype of teenage parents as a homogenous group. Similarly there appears to be a persistent perception that young women become pregnant intentionally to gain access to social housing. There exists evidence to the contrary that young women are not aware of what they are entitled to from the system until they become pregnant (Allen and Bourke-Dowling, 1998). Greene (2003) argues that current policy fails to reflect the complexities associated with poverty, lack of opportunity and social exclusion surrounding teenage pregnancy, and could exacerbate rather than alleviate young mothers' social exclusion. This is an important argument within the thesis as it is based on the premise that government policy is not being targeted to address the real problems facing young mothers, but are in fact problematising them in a way which adds to their exclusion.

Hoggart (2003) states that even though the UK has the highest rate of teenage births in Western Europe, it is not immediately obvious why this should be viewed as a social problem. The previous UK Government argued that this is because of the negative effects on teenage parents themselves. This includes outcomes such as a greater likelihood of having no qualifications, being in receipt of state benefits and having a lower income than any other group, as well as a greater likelihood of the children of teenage parents being raised in a lone-parent family, living in poverty and in low quality housing (SEU, 1999). Therefore it is important to explore how the complex relationship between teenage parenthood, poverty and disadvantage be more clearly understood.

Although teenage births may be associated with an increased risk of some adverse pregnancy outcomes, teenage mothers have a reduced risk of delivery by emergency caesarean section, therefore Smith and Pell (2001) question whether teenage pregnancy should only be considered to be a public health problem as it often occurs in the context of socio-economic deprivation (Smith and Pell, 2001). Although some studies have suggested that teenage pregnancies have a higher frequency of adverse perinatal outcomes, there is an argument about whether this is an independent association, or explained by confounding factors, whereby researchers have failed to adjust for factors such as smoking and socio-economic deprivation (Smith and Pell, 2001).

The adverse outcomes outlined by the Social Exclusion Unit could be attributable to the economic and social context rather than the pregnancy itself (Jewell et al, 2000). Lawlor et al (2001) explores this argument in more detail and draws comparisons with the prevailing culture for many women to delay childbirth. Lawlor et al (2001) assert that the idea that teenage pregnancy is an important public health problem should not be accepted without question. There is no biological reason to suggest that having a baby before the age of 20 is associated with ill health. It is increasingly common for women to delay having their first child until they are in their 30s, and yet these women are not labelled a

public health problem, even though their babies have an increased risk of perinatal death. Instead, the problematisation of teenage pregnancy could be considered to be what is really a reflection of what is socially, culturally, and economically acceptable in the UK (Lawlor et al, 2001).

The key message suggested in much of the literature is that the inequalities experienced by young parents are not as a result of having a child whilst relatively young, but are a preceding and ongoing fact of their lives. There is little doubt that becoming a parent does severely limit many young mothers' future lives. However many of the women who become young mothers grow up experiencing problems of multiple deprivation, and already have limited opportunities for the future.

In the following chapters, the thesis questions whether the government's drive to *reduce* teenage pregnancy (as opposed to improving support to teenage parents) is in fact an appropriate public health aim, and also questions whether the government's aim of tackling teenage pregnancy, through improved support, has been effective in inhibiting young mother's social exclusion. For the purposes of this thesis, social exclusion is defined in terms of a lack of resources to participate in normal relationships and activities that the most other people in society have access to (see Levitas et al, 2007).

Summary

This chapter has explored the nature and extent of the problem of teenage pregnancy within the UK (and more specifically within Salford). This has included exploring the socio-economic factors associated with becoming a teenage mother, and the poor outcomes that are linked to young motherhood. Following this an overview has been provided of the government's agenda around tackling teenage pregnancy through predominantly prevention initiatives and also through increased support for young mothers.

Chapter 3 - Teenage pregnancy and theoretical perspectives on social capital and social support

In light of findings from the literature review this chapter considers concepts of social capital and social support in relation to young motherhood. A range of support services aimed at young mothers have been implemented in line with policy directives. Within this context, concepts of both formal and informal social support for young mothers will be explored.

3.1 Understanding social capital

Social capital is suggested as a mediating link between socio-economic inequality and health. Wilkinson (1996) suggests that socio-economic inequality affects health because it erodes or inhibits social capital. The concept of social capital as a determinant of health and well being is an idea that has been written about a great deal in recent years (Cooper et al, 1999; Blaxter and Poland 2004; Coulthard et al, 2001; Sixsmith et al, 2001; Campbell et al, 1999; Whitehead and Diderichsen, 2001). It offers an explanation of how factors within the social environment can impact upon both physical and emotional health, including anxiety, stress and depression, as well as impacting upon mortality rates within areas.

Social capital can broadly be described as the resources within a community that create family and social organisation. Key constructs within the concept, often use indicators such as social relationships, formal and informal social support networks, group membership, trust, reciprocity and civic engagement. Social capital is concerned with groups rather than the property of one individual (ONS, 2001). There is a considerable amount of research being carried out on the relationship between health and social capital (Cooper et al, 1999; Blaxter and Poland, 2004; Coulthard et al, 2001; Sixsmith et al, 2001; Campbell et al, 1999, 2000; Whitehead and Diderichsen, 2001). This evidence suggests that social capital may act as a buffer to the effects of stress and that it generates a sense of well being and belonging. The General Household Survey now has a social

capital module, which investigates five areas of social capital. Three relate to the local community (views about the local area, civic engagement, reciprocity and local trust) and two relate to the individual (social networks and social support) (Coulthard et al, 2001).

The Organisation for Economic Co-operation and Development (OECD) defines social capital as "networks together with shared norms, values and understandings that facilitate co-operation within or among groups" (Klasen, no date provided). The World Bank (2000) definition goes further to say:

"Social capital refers to the institutions, relationships and norms that shape the quality and quantity of a society's social interactions....Social capital is not just the sum of the institutions which underpin a society – it is the glue that holds them together."

In his book 'Health and Wealth: Studies in history and policy', Szreter (2005) summarises the main theoretical developments on social capital. These draw on Bourdieu (1986), Coleman (1988), Putman (1993), Portes (1998), Halpern (1999) and Woolcock (2001). Portes (1998) suggests that the concept behind social capital is nothing new in sociological terms. For example Portes (1998) argues that Durkhiem proposed that involvement and social support were a solution to suicide by emphasising being connected in a community as an "antidote to anomie and self destruction". More recently the value of social capital was identified by Bourdieu (1986) and given a clear theoretical framework by Coleman (1988, 1990) who was the first to subject the concept to empirical scrutiny and develop ways of operationalising it for research purposes. However it is most commonly associated with Putman (1993) who applied it outside of academia and into the wider media.

Putman is the most well known theorist on social capital. Putman defines social capital as "networks, norms, and trust that enables participants to act together

more effectively to pursue shared objectives." Putman argues that it is important that any definition of social capital focuses on its sources rather than its consequences i.e. on what social capital is rather than what it does. Social capital has entered the field of public health through the work of two writers. Putman (1993, 1995, 2000) whose work on social capital did not in its self address public health issues but local democracy, and secondly, Wilkinson in 1996 in his book 'Unhealthy Societies' which was more directly relevant to public health.

The return to the social circumstances approach to public health has in part been fuelled by the disappointing results observed from a number of neo-liberal policy interventions and a growing recognition that more sophisticated medical advances and media campaigns have had little effect on addressing society's social ills (smoking, depression and teenage pregnancy). Szreter (2005) focuses his debate on the persistence of health inequalities in affluent societies. He considers the extent to which research and policies should prioritise the psychological experience of individuals and their relationships to others in their community and society, or the material deprivation due to overall economic structures and national political choices.

3.2 A critique of social capital

Social capital theorists agree that social capital is a resource and is essentially about social networks, trust and reciprocity and how people use these networks to better their social position. There are a number of criticisms of social capital that consistently appear in the literature. Most relate to how social capital is operationalised or measured. Social capital can be considered to be an ambiguous concept and defined in many different ways which renders it difficult to measure accurately. It could be argued that in order to understand the nature of social capital qualitatively it is necessary to break down each aspect of it into smaller elements of individual investigation i.e. social support. Many attempts at measuring social capital have been 'quick and dirty' using single item measures

as a proxy, such as the percentage of a population stating, "most people can be trusted". However, these types of measures do not recognise how respondents in different contexts define trust (ONS, 2001). For this reason it may be more helpful to explore the exact nature of the social capital and its strength or quality, and how it is perceived.

Forbes and Wainright (2001) argue that to know what group membership means, it is important to know much more than whether it happens or not, but the nature, role and function of the groups. It is argued that simply counting the number of people in a social network, or a particular organisation, indicates little about the strength of the social capital if it is not accompanied by information on what people do as members (ONS, 2001).

In addition, social capital is generally perceived as a community characteristic; however it is usually derived from aggregating the replies of individuals. This is considered problematic because collective social capital cannot simply be the sum of the individual social capital. It is also suggested that there is a need to measure the quality of social capital, not merely quantity (ONS, 2001). Secondary analysis of survey questions used to measure social capital revealed varied theoretical and disciplinary perspectives on which surveys are based resulting in ambiguity and diffuseness, arising from the inevitable ignoring of the specific context of people's lives. In their review of questions used in surveys to measure social capital, Blaxter and Poland (2004) identify the following six categories that questions tend to fall into:

- Social networks/ support
- Cohesion, reciprocity and personal trust
- Control, self-efficacy
- Commitment, civic engagement
- Institutional trust
- Perception of local environment

Social capital is a problematic concept, in part because it is a multidisciplinary concept. Among political scientists and psychologists, social capital is referred mainly to attitudes and norms, whereas sociologists tend to view it more in terms of structural variables operationalised in organisations and networks (Blaxter and Poland, 2004). Questions appear to measure both the things thought to create social capital and the things which are the consequences of greater or lesser amounts of social capital. Social networks and support create social capital, but high social capital creates cohesive societies (Blaxter and Poland, 2004).

The concepts used are not distinct or clear: the same questions are used to measure different things. For example, the quantity of personal social interaction – social network – is a relatively clear category, usually based on frequency of contact with friends and neighbours. Blaxter and Poland (2004) argue that when the quality of this interaction is questioned, the category begins to overlap with reciprocity or cohesion. It is of course possible to have available, or interact with, a large number of people, and yet still experience no help or support.

A further criticism of social capital is put forward by Morrow (2000) who disputes Putman's emphasis on civic participation as a key element of social capital. It is argued that civic participation is somewhat limited in the case of young people, given that they are positioned outside of democratic structures by their very nature (they do not attain the right to full adult citizenship in terms of voting rights until the age of 18). Particularly as Campbell et al's (1999) research on the relationship between social capital and health in adults, found that civic engagement appears to be more health enhancing than other dimensions of Putman's Social capital. So in the case of young people, they may feel reasonably well supported by networks of friends and family members, but the balance seems to go the other way when one considers their sense of self-efficacy and participation in their neighbourhoods, which is clearly limited. This is an important point in terms of young mothers' social networks and the

opportunities they have to participate in their community, possibly further exacerbated by their stigmatised status. So not only are there few opportunities for young people to participate outside of their own network of peers, this may be the case even more so for young mothers who feel even more reluctant to participate in their communities where the local community or wider media are critical of their moral conduct or parenting skills.

Portes argues that amongst the beneficial consequences of social capital are: social control and the provision of parental or kinship support. However social capital also has a downside as it may be used to constrain opportunities to non-network members, to place excessive demands on network members, to restrict individual freedom or reinforce delinquent behaviour, where this is a defining characteristic of the group (Hawe and Shiell, 2000).

Social networks and membership of institutions have similarly been shown to have ambiguous relationships with civic commitment or with health. It has been argued that it is not simply the number of networks but their structure and the individual's position in them that are important (Foley and Edwards, 1999). It has been queried whether civic associations necessarily have a positive effect on the broad public interest, and also that social networks may limit members' connections with the wider community. Networks can be exclusive as well as inclusive and may serve selfish as well as public ends. Strong links between individuals can both increase and decrease the risk of certain health outcomes (Berkman and Kawachi, 2000). Similarly Portes (1998) highlights the potential negative side to social capital as the exclusion of outsiders, restriction on individual freedom and a downward leveling of norms. By the latter, he uses as an example a situation whereby group solidarity is cemented by a common experience of adversity and opposition to mainstream society.

An additional criticism with research which seeks to link concepts of social capital to health is that it not clear which kinds of networks – weak or strong,

homogenous or heterogeneous- are the most effective in the creation of social capital and protecting health. Research into network analysis has shown that weak and strong ties can have different effects and benefits (Berkman and Kawachi, 2000). Explanations include those which suggest that relationships involving similar persons foster understanding and support, where as dissimilar persons in loose networks with weak ties provide wider access to diverse resources. Therefore if perceptions of inequality are detrimental to health, then perceived homogeneity might well be crucial. This analysis may be particularly important with regard to young mothers' social networks, where peer networks of support with other young women in similar circumstances may be of significance in terms of support for young mothers.

3.3 Social capital as a constituent of social exclusion

MacDonald et al (2005) conducted a qualitative, longitudinal study to explore the experiences of socially excluded young people during their transition from school into their 'adult careers' in terms of their housing and employment opportunities. This study found that social capital within local networks proved beneficial in helping young people cope with problems of growing up in a deprived neighbourhood by instilling a sense of inclusion. Paradoxically, the social capital extant in the networks also limited opportunities and the possibilities of escaping from the conditions of poverty. Young people living in deprived geographical areas were followed over a four-year period. Participants recognised the problems they experienced living in the areas, such as crime for example, they also greatly valued the sense of community spirit, and had strong attachments to their communities. Interestingly, young mothers were identified as a group with a strong desire to stay near their families for emotional and practical support.

The study highlighted how young people are not only disadvantaged by growing up in areas deprivation, but then can also become trapped by it. This might be exacerbated for young mothers, whose ties to their family may be even stronger in terms of support needs, and whose opportunities to find employment outside

of an area may be limited even further than for other young people without a child.

A further criticism levelled at the concept is that it represents an example of 'Third Way' rhetoric. It is argued that although social capital may have a well-established relationship with the outcomes that policy makers are interested in, such as economic growth, social inclusion, improved health and more effective government, social capital could be considered to be a convenient justification for a retreat from expensive welfare spending (ONS, 2001).

Hawe and Shiell (2000) argue that there is a danger that social capital rhetoric can be used to disguise conservative and unacceptable solutions to structural problems. Blaxter and Poland (2004) argue that a social capital focus to improving health with the most deprived communities should not detract attention from the need to channel real material resources into these populations.

Social exclusion embraces a view of poverty concerned with multiple aspects of deprivation, with the role of neighbourhood, with process and dynamics over time. Instead Cattell (2001) argues that we should return to Townsend's (1979) conception of relative poverty, where material resources are so seriously low as to exclude people from everyday living patterns, customs and activities, and build on it by recognising the complex and recursive relationship between an array of resources and social capital (Cattell, 2001).

Following this criticism of social capital, Szreter has written extensively about the contradiction between social capital versus material deprivation approaches to explaining health inequalities and social exclusion, and his work is able to draw some reconciliation between these two differing explanations, which is of key relevance to this study. In some ways the work of Szreter can be considered to complement the work of Levitas (1999) described in the next chapter in that of

the approaches described, one focuses on the material deprivation explanation, the other on a deterioration in the social support infrastructure.

3.4 Types of social capital

Putman's work focuses on civic associations and the fall off of individuals to participate in a range of activities together over the past few decades. Putman attributes this to the lifestyle of the two generations raised since World War II who are characterised by sub urbanisation, long commutes to work, dual careers and the advent of television. Putman refers to different types of social capital, which are termed 'bonding' and 'bridging'. Putman describes a process whereby not all forms of social capital or network association inspire trust and confidence between members that serve the best interests of the wider community or the network members. Street gangs could be used as an example of this which Putnam had previously explained by distinguishing between networks that were based on 'horizontal' egalitarian relationships and those that were built on 'vertical' hierarchical relationships, whereby only 'horizontal' relationships could produce genuine social capital.

Bonding social capital refers to trusting and cooperative relationships between members of a network who see themselves as being similar in terms of social identity. Whereas bridging social capital comprises of relationships of respect between people who know that they are not alike in some sociodemographic sense. Therefore, it seems that Putman's particular concern was with the decline in bridging social capital.

More recently the concept of 'linking' social capital has emerged. This can be defined as norms of respect and networks of trusting relationships between people who are interacting across explicit formal or institutional power gradients. Linking social capital is particularly important to this study as it explores the role of formal services in developing social capital. This is particularly relevant to accessing public and private services that can only be delivered through face-to-

face interaction such as in general practice for example. Srzeter argues that in poorer communities access to welfare largely depends upon the nature of respectful and trusting ties to representatives of formal institutions such as social workers or health care providers.

Therefore, health outcomes can not only be improved by expanding the quality and quantity of bonding social capital (among friends and family); through bridging social capital (trusting between those from different demographic and spatial groups) and; by the building of linking social capital across power differentials, especially to representatives of institutions responsible for delivering key services in poor communities.

3.5 Understanding social support

Social support is of particular relevance to young mothers as these mothers as they usually experience multiple risks factors for poor social outcomes. Firstly, they are predominantly from more disadvantaged groups and as such may lack opportunities, and experience the day to day stresses associated with living in poverty. Secondly, they are new mothers, which makes them more vulnerable due to their changed and changing role and the stress associated with pregnancy and childbirth, and so may be more susceptibility to postnatal depression. Thirdly, they may be experiencing a stigmatised status, which could lead to changes in the social support available to them, in both formal and informal settings, and may find sources of support diminished due to public disapproval .

Social support may be particularly significant to the experiences of young mothers. It is important to explore the concept of social support in detail. Social support can be defined as a well-intentioned action that is given willingly to a person with whom there is a personal relationship and that produces an immediate or delayed positive response in the recipient (Hupcey, 1998). Social support has been linked with health and avoidance of disease by multiple researchers since the 1970s (e.g. Caplan, 1974, Cassel, 1974, Cobb, 1976).

There is empirical evidence that social support may have both direct and buffering effects in its positive influence on health, particularly in relation to coronary heart disease (Cohen and Syme 1985).

The importance of social networks and their characteristics lies in the extent to which they fulfil members' needs. Their function can be summarised as 'that set of personal contacts through which the individual maintains a social identity, and receives emotional support, material aid, services, information and new social contacts' (Walker et al, 1977). House (1981) has suggested that social support involves emotional concern (liking, love); instrumental aid (services); information (about environment) and appraisal (information for self-evaluation). One approach to defining social support comes from the consideration of its source, such as who provides it; the functions it serves for people (e.g. material aid); and the intimacy of the relationship (e.g. whether it is a confiding relationship). Therefore, social support can be defined as the interactive process in which emotional, instrumental or financial help can be obtained from an individual's social network. Cobb (1976) defines social support as 'information leading the subject to believe that they are cared for and loved, esteemed, and a member with mutual obligations'. Therefore, it can be assumed that support exists only if an individual perceives it to exist.

Social support may be seen as emotional, instrumental and financial aid that is obtained from a social network. Support is generally considered as an exchange or transaction between people (Berkman, 1984).

Weiss (1969) outlines seven major functions of social support:

- Intimacy: the provision of an emotional climate in which individuals can express their feelings freely without self-consciousness. Without this feeling of intimacy individuals can experience isolation often expressed as 'loneliness'. Marriage or a marriage type of relationship often fills this.

- Social integration or sense of belonging: the provision of a sharing of experience or information, and ideas though relationships in which participants share concerns because of similar situations. Friends, colleagues and neighbours often provide this sense of integration.

- Opportunity for nurturing behaviour: expressions of nurturance are most often thought of as occurring in relationships in which adults take responsibility for the well being of a child, but could also include caring for a relative, or teaching new skills to students or new colleagues. This function emphasises the value to self-obligations and duties towards others in addition to support received from them.

- Reassurance: relationships function to reassure an individual's competence in some role, and an individual's worth. Both colleagues and family often provide this sense of value.

- Assistance: the provision of tangible goods (food or money) or task-orientated services (cooking, childcare) is an obvious function of social relationships. This is most often friends and family who provide this type of support over a long period of time.

- Guidance and advice: the communication of advice or appraisal of a situation. Professionals may be particularly useful at providing this type of support. Network members may provide feedback concerning the evaluations of actions an individual is considering.

- Access to new contacts and diverse information: Weiss (1969) also suggests that networks may lead to new sources of information and new contacts that may be helpful under certain circumstances.

Using a variety of direct and indirect measures, researchers have found associations between social support and social networks and mortality, chronic diseases, depression and psychological disorders, and other health and medical problems (O'Reilly, 1988). The lack of a strong network of social relationships has been located as a major risk factor with implications as serious as those for smoking and high blood pressure. These risk factors are typically clustered in populations with lower socio-economic status, and has led to the hypothesis that social support constitutes a causal link between poverty and poor health. Evidence suggests that more disadvantaged groups have lower levels of social support to act as a 'buffer' against stress and thus are more vulnerable to disease (House et al, 1988, Berkman, 1984).

In a seminal paper 'The contribution of the social environment to host resistance', Cassel (1976) put forward the evidence that social support gives protection against stress-related physical morbidity through cushioning individuals against stressful experiences. The protective effect of a confiding relationship was proposed by Brown and Harris (1978) for depression. Both of these frequently cited papers have undoubtedly led to many subsequent investigations of the links between social support and health (Henderson, 1984).

Following these papers, a huge amount of research has produced evidence pointing to links between social support and psychological well being (Dean and Lin, 1977, Gottlieb, 1985, Kessler, Price and Wortman, 1985, Turner, 1983) and suggesting that a level of social support may be particularly relevant for depression (Brown and Harris, 1978). House et al (1998) concludes that:

Why is social support so important to young mothers? It is hypothesised that supportive relationships are likely to be of particular importance during stressful life events, for example, the experience of pregnancy and childbirth. Recognition of child bearing as a process that bridges social and biological domains leads to a hypothesis that psychosocial factors of significance for health and illness states

may also be influential in relation to pregnancy outcomes. This hypothesis was confirmed in relation to the evidence on life stress in a study by Turner et al (1990).

The extent of family support was found to be by far the most powerful indicator of depression among young mothers. Those living with parents had significantly lower rates of depression (Turner et al, 1990). Similarly friend support was found to be an important factor in terms of depressive symptomatology. Turner et al (1990) found a clear compelling relationship between social support and complications during childbirth among women with a high level of life stress during and before pregnancy. Those with low social support were three times more likely to have complications as those with high levels of support. This led to the conclusion that in the presence of a high level of stress, social support acts as a buffer in relation to the occurrence of complications (Turner et al, 1990).

Therefore Turner et al (1990) concluded that if social support is of such relevance for complications amongst adult married women (for whom childbearing is likely to be surrounded by approval, pride and pleasure), the significance is likely to be much greater in the dramatically different circumstance experienced by pregnant and often-unmarried teenagers. This point is also made by Huff (1987):

"Pregnancy is a challenge in any female's life regardless of the circumstances. However, for the adolescent the crisis is greatly intensified because it adds another level of complexity to an already complex period of physical and emotional change". (Huff, 1987)

3.6 Social support and teenage pregnancy: What is the evidence?

Barrera (1982) considered the relationship between life stress, social support and adjustment to pregnancy in his study of 86 pregnant adolescents. This is particularly salient as it can be applied to the support received by individuals from

formal services, rather than just exploring informal support. Barrera concludes that qualitative experiences of support prove to be the strongest predictors in symptomatology. Therefore, this can be interpreted as the knowledge of people's subjective appraisal of the adequacy of the support is more critical to the prediction of their well being, than simply collecting information on the quantity or number of supporters to which they have access. Barrera's study, using the ISSB is highly relevant to this study as it provides a framework to explore social support qualitatively, whilst also being flexible enough to explore socially supportive behaviours from both formal and informal sources.

A study by Moffitt (2002) compared the social circumstances of teenage mothers living in the UK with mothers who delay childbearing until after the age of 20. Young mothers in this study received less social support than their older peers from every source except official agencies. The younger participants received less child-rearing help from current partners and reported slightly less help than older mothers from friends and family. Young mothers also lived in neighbourhoods that were perceived to be less cohesive where people were unwilling to help neighbours, for example. Mothers who gave birth before the age of 20 were found to be more socio-economically deprived and have significantly less human and social capital.

Macleod and Weaver (2003) undertook a study to examine attitudes and adjustment to pregnancy in young mothers in the UK. In relation to formal social support provision, service providers such as midwives were rarely cited within participants support networks. Participants felt well supported by their families, and most had a positive attitude towards the pregnancy. The study also found a correlation between satisfaction with social support and attitude towards pregnancy. However, interestingly, no correlation was found between size of network and satisfaction with social support, attitudes or happiness. Macleod and Weaver do not provide an understanding of exactly why and how family

support, rather than, for example, the size of the networks, is important to positive pregnancy attitudes and adjustment.

Passino et al (1993) conducted a study that suggested that pregnant teenagers would not be as socially competent or as well adjusted as their non-pregnant peers and pregnant adults. The findings revealed that pregnant adolescents were less involved than non-pregnant adolescents in interpersonal relationships, more specifically they had less frequent and less positive involvements with their peers and family. This was considered significant by the authors as this kind of social interaction can serve as a major source of social support and as a buffer against stress. Similarly pregnant adults were more likely to rely upon their spouses for social support than on their friends. Therefore, the pregnant teenagers who were more likely to be single did not have access to this support. Thus, pregnant teenagers were found to be facing a critical life event with reduced social support systems (Passino et al, 1993).

McDermott et al (2004) undertook a systematic review of the qualitative literature relating to the experiences of young mothers. It was found that there is strong evidence that family relationships are fundamental to the ways in which young mothers cope with early mothering, and that the central figure of family support for young mothers was their own mothers (McDermott et al, 2004). Kin relationships offer emotional, financial and practical support which was fundamental to sustaining young mothers and their children.

The evidence suggests that social relationships, or the lack of, constitute a major risk to health and well being, which may be as important to health as established major risk factors such as cigarette smoking, high blood pressure, obesity and physical activity, which has severe implications for future public policy (House et al, 1988). Social support is of particular importance to young mothers. In terms of understanding social support as a means of improving health and reducing inequality, this requires an understanding of the broader social, as well as the

psychological and biological, structures and processes that determine the quantity and quality of social relationships and support in society (House et al, 1988).

Summary

As a concept which bridges structural and cultural approaches to poverty, social capital is a useful tool in understanding the relationship between poverty, place of residence, and health and well being. However, Cattell (2001) asserts that on its own, the concept is not adequate for explaining the poor outcomes associated with teenage pregnancy. What is required is a greater understanding of how support networks can be fostered within communities to improve opportunities for young mothers, a socially excluded and stigmatised group. Linking social capital refers to relationships between individuals and groups in different social strata in a hierarchy where power, social status and wealth are accessed by different groups and the capacity of the members to leverage resources, ideas and information from formal institutions beyond the community.

Solid evidence links informal social networks, social activities and participation in organisations, with better life chances. Networks can provide social support, self-esteem, identity and perceptions of control. Both formal and informal social networks are essential components of 'social capital'.

The links between social support and health have been explored in this chapter, and more specifically the significance of social support to young mothers' well being. There are large amounts of literature highlighting the relationship between social support and physical and emotional health and well being. In addition evidence stressing the importance of the relationship between social support and young motherhood has been presented.

Ultimately social support can be considered to be of particular relevance to young mothers as they may be experiencing multiple risk factors in terms of

experiencing reduced social support. Firstly, they are a disadvantaged group. Secondly, they are young, which makes them more vulnerable due to their changing role, their changing support needs and the stress associated with pregnancy and childbirth. Thirdly, they are a socially excluded group, which could lead to changes in the social support available to them, in both formal and informal settings.

It has been argued in this chapter that social support has the potential to constitute a form of social capital at a number of different levels. Firstly, at a bonding level, predominantly through informal networks, kin and friendships, and secondly, at linking level through the provision of formal social support services.

Chapter 4 – The social exclusion agenda: does it help young mothers to be socially included?

Notions of social inclusion and exclusion will be discussed in this chapter and an exploration of how government policy and the resulting formally provided services have attempted to help young mothers to become socially included will be presented.

4.1 The 'Third Way' ideology and social exclusion

It is useful to explore the concept of the 'Third Way' philosophy in order to understand the government's approach to the issue of teenage pregnancy and the consequences of this approach to young parents. The labour government introduced the idea of a Third Way approach to policy. The Third Way philosophy seeks to blur the distinction between Left and Right and to deconstruct political identities and allegiances entrenched upon traditional party lines.

This framework rests on the assumption of social justice in a world in which the old style welfare state is no longer sustainable or necessarily desirable. From this philosophical viewpoint arises the Third Way version of social inclusion and exclusion. This paradigm translates equality as inclusion and refers to such concepts as citizenship, and '*the civil and political rights and obligations that all members of society should have as a reality of their lives*' (Giddens, 1998, pp.102-103). Conversely '*exclusion is not about gradations of inequality, but about mechanisms that act to detach groups of people from the social mainstream*', i.e. from citizenship and civic life (Giddens, 1998, p.104).

Those affected by these combinations of risk factors and circumstances are also the most likely to be affected by the SEU identified key factor in the high teenage pregnancy rate: low aspirations. The report found that:

"Throughout the developed world, teenage pregnancy is more common among young people who have disadvantage in childhood and have poor expectations of education or the job market. One reason why the UK has such high teenage pregnancy rates is that there are more young people who see no prospect of a job and fear they will end up on benefit one way or the other. Put simply, they see no reason not to get pregnant." (SEU, 1999, p.7)

The report goes on to imply that low aspirations, rather than being linked to a particular social grouping, are in fact the product of the culture of welfare dependency and associated with the already socially excluded. However, this is not to say that such 'social considerations' diminish personal responsibility or mutual obligation (Blair, 1998).

It has been asserted that the New Labour's policy work on the issue of teenage pregnancy indicates a determination to specify some moral groundings of individual behaviour (Bullen et al, 2000). It could be argued that Blair has placed social exclusion and welfare reform, not merely as matters of economic necessity or ideological pragmatism, but set it within a new moral agenda. According to Blair, 'the Third way is not an attempt to spoil the difference between Left and Right. It is about traditional values in a changed world' (Blair, 1998, p.1). Welfare reform has been at the heart of New Labour's search for a new middle way. Welfare-to-work is emblematic of the 'Third Way' approach, because on one hand it promises to save public money, and on the other, it aims to combat the harmful effects of 'social exclusion' through the moral, but also social, benefits of hard work (Penn and Randall, 2005).

The concept of 'social exclusion' can be considered to be a Third Way political ideology, which is particularly relevant when considering teenage parents. In the mid-1990s the UK was distinguished from other EU countries because of its high levels of social exclusion (SEU, 2001). The UK had the highest rates of children growing up in workless households, teenage pregnancy, and drug use amongst

young people in Europe (SEU, 2001). During the 1980s and 1990s crime doubled, child poverty trebled and numbers of school exclusions quadrupled (SEU, 2001). In addition to this, rates of homelessness and alcoholism amongst young men were on the increase (SEU, 2001). These social problems were one of the key underlying factors in the concept of social exclusion. Social exclusion can be considered to be a relatively new idea in British political debate. The idea endeavours to understand the links between low income, unemployment, crime, poor housing and family breakdown, in order to address this using appropriate policy (SEU, 2001).

In the UK, the government's focus on social exclusion has been around workless households (Burchardt et al, 1999). Burchardt et al (1999) argue that, for some, social exclusion is simply the fashionable way of talking about poverty. Whereas for others, it is a broader conception, which does not focus merely on low income, but is concerned with concepts such as polarisation, income differentiation and inequality. Giddens (1998, p.104) states that "Exclusion is not about graduations of inequality, but about mechanisms that act to detach groups of people from the social mainstream".

4.2 Defining social exclusion and its development

In a report by the SEU (2001) it is acknowledged that although social exclusion can happen to anybody, certain groups within society appear to become disproportionately victim to it. The report identified a number of specific groups in which social exclusion needed to be tackled, such as homeless people, and those excluded from school. Teenage mothers were identified as a group being at increased risk of social exclusion.

Levitas et al (2007) provide a detailed analysis of the definitions of social exclusion in order to identify appropriate 'dimensions' contributing to multiple disadvantage. In so doing, Levitas provides the following working definition:

"Social exclusion is a complex and multi-dimensional process. It involves the lack or denial of resources, rights, goods and services, and the inability to participate in the normal relationships and activities available to the majority of people in a society, whether in economic, social, cultural or political arenas. It affects both the quality of life of individuals and the equity and cohesion of society as a whole."

Within two years of the establishment of the SEU, the government created an annual audit of 'poverty and social exclusion'. The Opportunities for All reports beginning in 1999, define social exclusion as:

"When different factors combine to trap individuals and areas in a spiral of disadvantage." (DSS, 1999, p23)

Levitas et al note that most approaches to defining social exclusion see poverty and social exclusion as an inseparable dyad. However there are approaches in the UK, European and global literature that see social exclusion as distinct from poverty (Levitas et al, 2007). These definitions refer to structures, processes and characteristics of the society as a whole, as well as to the experiences of the individuals situated within it. References to economy, politics and society, power and inequality highlight the structural causes and contexts of the individual experiences of exclusion.

"An accumulation of confluent processes with successive ruptures arising from the heart of the economy, politics and society, which gradually distances and places persons, groups, communities and territories in a position of inferiority in relation to centres of power, resources and prevailing values." (Estivill, 2003, p.19)

Levitas et al (2007) argue that the SEU use social exclusion as a label for what can result when individuals or areas suffer from a combination of linked problems

such as unemployment, poor skills, low incomes, poor housing, poor health and family breakdown (SEU, 2001). Other definitions are concerned with *'the inability to participate effectively in economic, social, political and cultural life, alienation and distance from the mainstream society'* (Duffy, 2005). Or Walker and Walker (1997) define social exclusion as *'the dynamic process of being shut out…. From any of the social, economic, political and cultural systems which determine the social integration of a person in society'*. Therefore, social exclusion can be considered to be a multi-faceted concept, Levitas argues that it is related to poverty, particularly to the understandings of poverty that go beyond low income and address the multiple dimensions of deprivation.

Levitas (1999) has developed a model, which identifies three approaches to explaining social exclusion. The model puts forward a number of differing approaches or discourses to addressing social exclusion based around material deprivation, social integration through paid employment and finally a moral integration discourse.

The first approach is a redistributive discourse (RED), whereby social exclusion is seen as a direct consequence of poverty. Levitas presents Townsend's (1979) explanation of poverty, whereby poverty should be understood not in terms of subsistence, but in terms of people's ability to participate in the customary life of society. A key focus of the RED approach to addressing social exclusion would therefore be to raise benefits in order to reduce poverty.

Levitas (1999) argues that current government policy is rooted in a different model of social exclusion in which the key element is labour-force attachment. Levitas (1999) argues that this is concerned with a discourse about social integration (SID), whereby paid employment is represented as the only legitimate means of integrating individuals into society. The excluded are the 'workless' or in the case of young people, those who are at risk of becoming workless. Unlike the RED explanation of social exclusion, SID glosses over ways in which work

may fail to prevent exclusion, such as in low paid jobs. Whilst an indicator for RED would be low income, for SID it would be unemployment or 'economic inactivity' – a concept that intrinsically denies the value of unpaid work.

The third approach is a moral underclass discourse (MUD), which emphasises the moral causes of poverty. This approach is concerned with the moral hazard of 'dependency' and workless households. MUD focuses on the consequences of social exclusion for social order and on particular groups such as potentially criminal young men, lone parents and, especially, young, unmarried mothers. MUD also finds a connection between poverty and social exclusion, but sees the causes of poverty as lying in moral (self) exclusion rather than the other way round.

4.2.1 Redistributive discourse (RED)

In relation to the redistribution approach to teenage pregnancy Levitas questions why indicators such as 'births to women under the age of 19' became a priority indicator for social exclusion by the SEU. Levitas (1999) argues that there are three disadvantages to prioritising such indicators. Firstly, there is a danger of further stigmatising the 'excluded' groups; secondly the failure to explore why teenage pregnancy results in poverty and social exclusion (for example, this may be due to the poor level of benefits) and, thirdly the implied size of the problem. Levitas (1999) makes the point that there were 59,700 births to 15-19 year olds in 1996/97, compared with 3.3 million children living in households with below half of the average income, during the same time period, or a total of 10.5 million individuals of all ages living in such households. Levitas (1999) argues that by focussing on particular social groups the government is diverting attention from the broader prevalence of social exclusion, and from the link with poverty and the causes of poverty.

Byrne (1999) describes a process whereby increasing inequality is the product of two broad tendencies; a shift in the share of incomes from wages and property

and a cut in welfare and increasing disparity in earned incomes. Certainly, Byrne (1999) goes on to argue that there is evidence that social mobility is closing down in post-industrial societies. There is considerable evidence to support the existence of a separation of the ever more affluent few from the remaining static, or actually becoming poorer, many (Byrne, 1999).

"However social exclusion is not usually described in terms of the majority, it is about the 'sloughed off' minority at the bottom of society separated by material poverty and increasingly distinguished by negative cultural characteristics. These people are not just poorer. They are different." (Byrne, 1999, 70)

Although social support and social capital are considered to be key elements to the social inclusion of young mothers, on their own these two factors are likely to have only limited impact. Material deprivation approaches and redistribution need to occur simultaneously with social support.

4.2.2 Social integration discourse (SID)

Kidger (2004) explored the limitations of policy aimed at supporting young mothers in relation to social exclusion. The study explores the two main political and academic schools of thought around the conceptualisation of social inclusion/ exclusion. One is concerned with the ideas of belongingness, social cohesion and the integration of social groups. Whilst the other is more concerned with ideas about inequality and material deprivation, to the extent that at its simplest definition the term 'social exclusion' has been used interchangeably with the term 'poverty'. Kidger (2004) asserts that New Labour's approach to tackling social exclusion through the TPS adopts the material deprivation conceptualisation of the term. It is argued that the strategy equates social inclusion with economic self-sufficiency through promoting policies to encourage young mothers to return to education or employment. Instead, Kidger (2004) argues, there is an emphasis on the responsibility of individuals to earn social inclusion. Kidger (2004) concludes that New Labour's emphasis on

inclusion through participation in work could be criticised for putting the responsibility for achieving social inclusion on to the individual, rather than considering it to be a moral right.

Taking an employment based approach to 'tackling' teenage pregnancy has been criticised for not valuing the role of motherhood at a policy level. Firstly by equating motherhood with low aspirations. Milne-Home et al (1996) state that women are caught in a double bind of societal disapproval, as their mothering role which society disapproves of then becomes deprecated in their absence of a nuclear family formation. And secondly for forcing single mothers into employment.

"The simplistic employment-based assumption for reform falls into the trap of seeing single mothers, dichotomously – either as mothers or workers rather than both. It tends to assume that sufficient income is an adequate resource for good parenting" (Milne-Home et al, 1996)

It is argued by the government, that the trouble with poor and pregnant teenagers is that they do not engage in education, establish themselves in careers, marry a sensible hard working person before thinking about having a baby, in the way that middle class people do. However, Luker (1997) argues that many poor teenagers do these things, but that the odds are stacked against them, as people who lack education are less well off and thus find it harder to maintain a marriage and a family. Even if they work in a job at the bottom end of the minimum pay scale full time, this is likely to be insufficient to keep a family out of poverty. The idea that if young people simply worked harder, and were more patient and postponed their childbearing is not true for a great many people at the bottom of the income scale. Even when poor people obtain more education for example, this only serves to displace other people at the end of the queue, and the problem of poverty and childbearing among young people continues.

Social exclusion is often equated with permanent unemployment, but this is relatively uncommon compared with the situation of cycling from unemployment to poorly paid work and back again, cycling between full dependency on the welfare state and between dependency on supplemented low incomes. Social exclusion policies as they exist at present are all about moving people from the excluded to the merely contingent domains. They seek to do this through either or both training/ education and the supplementation of low wages.

The SID approach is currently favourable within government but it has been widely criticised in terms of its ability to genuinely tackle the social exclusion of young mothers.

4.2.3 Moral Uuderclass discourse (MUD)

The 'problem' of teenage mothers can be considered to be two-fold. Teenage mothers appear to be of concern to the community in a number of ways, the most significant being their cost to society. In financial terms, the majority of teenage mothers rely on government support for their subsistence. Secondly they are of concern in terms of their 'qualification' or suitability to parent (Hanna, 2001).

New Labour's policy around teenage pregnancy indicates a determination to specify some moral groundings of individual behaviour. Blair (1997, p.6) rejects the idea of '*rootless morality whose symptom is a false choice between bleeding hearts and couldn't care less*', and by doing this has positioned social exclusion and welfare reform not merely as matters of economic necessity or pragmatism, but within a new moral agenda.

The Third Way is about '*traditional values in a changed world*' (Blair, 1998, p.1) Bullen et al (2000) state that when sex and money combine as they do in the issue of teenage pregnancy, this becomes most apparent. They argue that the vocabulary of New Labour is symbolised in the rhetoric of moral civility, but in the main refers to those relying on welfare who are not bound by moral moorings as

a result of the detraditionalisation of such institutions as schools, families and the Church (Bullen et al, 2000).

In her book, Luttrell (2003) describes how discourses are institutionalised and taken-for-granted ways of understanding relationships, activities and the meanings about the way the world works. This understanding emerges through language and through the media, laws and educational curriculum, to medical practice, folklore and common sense, and influence what people believe to be 'right' (Luttrell, 2003).

"This discourse (relating to personal responsibility and blame*) also distorts our understanding of how social conditions and cultural forces converge to create isolation, troubled relationships and little support for many teenage girls (but especially those living in poverty) at a pivotal point in their lives....it points the finger of blame at those girls who make choices that do not adhere to a "normative" life trajectory."* (Luttrell, 2003, p.28)

It is crucial to recognise that not all mothers and children are affected in the same way. Unmarried mothers who have resources to raise their children on their own (without dependency on the state) can escape the intense scrutiny of being a 'wrong girl' or of being part of a 'wrong family'. Those other, 'undeserving' mothers who are dependent on others are the ones currently being scapegoated and stigmatised.

"In the context of the current political crisis of 'social reproduction' – struggles over who is to provide for children's well being and need, and who is responsible for children's socialisation (the state, families, individual women?) – the campaign against teenage pregnancy serves to translate what is a political problem into a problem of individual dependency. Put slightly differently – social instabilities bought about by globalisation, economic restructuring, and

diminished forms of social welfare are transposed into cultural symbols of vulnerability and dependency." (Luttrell, 2003, 36)

Levitas's model provides the means to begin to describe how young mothers become excluded and how it can be addressed.

4.3 The concept and dimensions of social exclusion

This chapter has so far explored social exclusion in relation to teenage pregnancy using Levitas's framework or approaches to tackling social exclusion. The chapter has explored how government policy is geared more towards social integration through employment, and a moralistic approach to the social inclusion of young mothers. The chapter will now consider the work on social exclusion undertaken by Burchardt et al (1999), Richardson and Le Grande (2002) and Levitas et al (2007) in relation to a broader approach to social exclusion, that may be more appropriate to supporting young mothers, and this includes formal service provision by the state, social support and social participation. These models are useful and relevant to this study as they contain categories relating to the provision of social support, and in particular formal support and demonstrate how social support and social capital have potential to lead to social inclusion.

"An individual is socially excluded if (a) he or she is geographically resident in a society but (b) for reasons beyond his or her control, he or she cannot participate in the normal activities of citizens in that society, and (c) he or she would like to so participate." (Burchardt et al, 2002, pp.30, 32)

Burchardt et al (1999) developed a definition of social exclusion based around the notion of participation in five types of activity (table 5):

Table 5 Burchardt et al's definition of social exclusion

Dimension	Exclusion	Indicator
Consumption activity	Low income	Income under half mean household income
Savings activity	Low wealth	Not owner-occupier, no pension, no savings
Production activity	Lacks production activity	Not in employment, education or training
Political activity	Politically unengaged	Did not vote in 1992 general election or member of political organisation
Social activity	Socially isolated	In any one of the five respects, lacks someone who will offer support (listen, help in a crisis, can relax with, really appreciates you, can count on to comfort)

Burchardt et al (1999) used data from the British Household Panel Survey (BHPS) to explore the extent of exclusion in Britain over each of the dimensions over the period of 1991-1995. In addition to this the study explored trends in the number of people excluded over time, whether it was the same people excluded on different dimensions

The findings revealed that although there were large proportions of people excluded on one dimension who were excluded on no others, no clear cut multidimensional category of socially excluded people can be identified using the indicators. Instead they suggest that the dimensions of exclusion are best treated separately rather than amalgamated into a single category of the 'socially excluded'. In addition, few people are excluded on all dimensions at any one time and few people are excluded over the entire time period. This model can be seen to encompass the concepts of social capital and social support into the wider framework of social exclusion. It could be further proposed that in this way one's informal social networks may be able to act as a 'buffer' against the effects

of social exclusion. These findings are also indicative of social exclusion as a dynamic concept. This model highlights the importance of social support and social capital within a definition of social exclusion, as it draws out social and political activity as key dimensions.

Levitas et al (2007) has developed a matrix of domains of social exclusion constructed across the four stages of the life course: childhood, youth, working-age adulthood and later life. The Bristol Social Exclusion Matrix, or B-SEM contains 10 domains of potential importance to social exclusion:

Resources:	Material/ economic
	Access to public and private services
	Social resources
Participation:	Economic participation
	Social participation
	Culture, education, skills
	Political and civic participation
Quality of life:	Health and well being
	Living environment
	Crime, harm and criminalisation

Similarly to Burchadt et al (1999) and Richardson and Le Grand (2002), Levitas includes public services, and social capital/social support type elements within her domains of social exclusion. These models of social exclusion draw together a broader spectrum of factors that could impact upon the social inclusion of young mothers, with a focus away from individual responsibility for gaining employment or inclusion, to a consideration of the wider social environment whether through informal social networks or through formal service provision.

The key point to consider is whether those who are defined as being socially excluded, such as young mothers, genuinely consider themselves to be so; do they themselves think that they are a 'problem'? It is questionable whether this is really the case, or rather whether the social support they receive within their own networks legitimises young parenthood within a culture where this is a perfectly

acceptable and rational life choice. If this is the case, the problem of teenage pregnancy can be considered to be a merely political-moral creation, where the poor outcomes associated with young parenthood are a result of pre-existing deprivation, rather than the early childbirth.

4.4 How do young mothers remain socially excluded?

Clearly a stigma continues to be attached to young mothers and raises questions not only about how teenage mothers are to be supported within the current political-moral climate, but in relation to preventive strategies proposed under New Labour. For example, a range of negative connotations is implicit in their terminology framing adolescent pregnancy and motherhood, concerned with moral aspirations, judgements about young people's parenting ability, and myths about welfare abuse (Milne-Home et al, 1996).

Hoggart (2003) argues that the government's recent attention around teenage pregnancy has been in many ways misleading, and the actual rates of teenage pregnancy have not in fact changed significantly since the 1970's. The teenage birth rate (15-19 year olds) was approximately 23 per 1000 in 1980, and the same in 1996. Thus, New Labour's publicity regarding the harsh reality of single parenting may lead to the further stigmatisation of an already stigmatised and alienated group, consequently leading to further the social exclusion experienced by young mothers.

Geronimus (2003) suggests that public attitude towards teenage pregnancy has been shaped by government rhetoric and policy:

"*To some extent teen pregnancy prevention has been officially controversial, it has generated debate between generations, political liberals and conservatives and feminists and advocacy organisations. None of which argue whether teenage childbearing is a social problem to be prevented, but merely the means*

by which it should be prevented, solutions ranging from sex education, contraception, abortion, abstinence, and welfare reform" (Geronimus 2003).

A study by Fessler (2005) reinforced this finding. The study described young mothers' perceptions of their stigmatised status having resulted in the adoption of avoidance behaviours which ultimately reinforced their marginalisation.

Luker (1997) examines what she terms as the 'controversial question' of the long term effects of teenage pregnancy, and to what extent having a baby while still a teenager compromises the life chances of a mother and child. Luker argues that while teenage mothers and their children tend to fair worse in many respects, it cannot be entirely attributable to 'untimely' parenthood. She explodes the myth that simply by postponing childbearing individuals' lives would be substantially improved.

Luker (1997) states that although the evidence is not yet conclusive, it is clear that persuading young people to postpone their childbearing would result, at best, in only modest changes. Perhaps they would be a little better off financially, perhaps a little more likely to marry, perhaps a little less likely to rely on welfare, but overall the effects would be small. The same social conditions that encourage teenagers to have babies also work to prevent them from ever being 'ready' to be parents in the way that a white, middle-class public might prefer. Pre-existing poverty, failure in school, a dearth of opportunities for personal and professional fulfilment, and traditional gender role expectations all lead both to early pregnancy and to impoverished lives.

4.5 Impact of government policy on social exclusion

Duncan (2007) presents a review of evidence that suggests that the age at which pregnancy occurs has very little impact upon social outcomes. Teenage pregnancy can have many positive outcomes for young parents including providing the impetus to take up education and training.

Duncan (2007) argues that a moral panic perspective is being taken whereby attention is distracted away from the inequalities that contribute to the existence of a problem, and instead focuses on attributing blame to individuals suffering from the problem. Teenage pregnancy has been subsumed within the welfare dependency debate, particularly in terms of neglecting the disadvantage explanations in favour of explanations concerned with ignorance and individual behaviour.

Teenage pregnancy not only raises the issues of sex, age and marriage, but also of poverty, dependency, and the difficulties of getting ahead in an increasingly competitive global economy. More subtly, it raises questions about 'family values', about the relationships of individuals to the community and about the competing claims of rights and obligations in this new economy (Luker, 1997).

Summary

This chapter has described the current political approach to discouraging young parenthood and provided a critical analysis of the 'Third Way' political-moral agenda, and the government's approach to social exclusion. An argument has been presented that rather than reducing social exclusion the 'Third Way' approach can be seen to actually add to the deprivation experienced by young mothers. Questions have been raised about whether outcomes of teenage pregnancy are a genuine public health problem.

The Government's approach which focuses on the individual's personal responsibility to become socially included through paid employment, may not be the most appropriate method to support young mothers to improve their lives. Instead it may be more appropriate to consider the more material deprivation and social support approaches to social exclusion, and in particular how formal services provided by the state can support young mothers to become socially included.

Chapter 5 - Methods

5.1 Research Strategy and methodology

The purpose of the study is to develop a conceptual understanding of the role of formal and informal support networks and social capital in the lives of young mothers and how these may help them to cope with motherhood and provide an opportunity for social inclusion.

The study aims and objectives are developed from a wider research question that seeks to examine teenage mothers' experiences of social support and social capital with particular reference to New Labour's emphasis on the TPS as a means to tackling social exclusion.

Aim: To understand the impact of social support networks in the lives of young mothers

Objectives:

- Describe the nature and function of teenage mothers' support networks both during and after birth
- To explore the role that these networks play in constituting social capital and in providing an opportunity for overcoming social inclusion
- To evaluate the impact of the TPS in supporting young mothers and promoting social inclusion

The purpose of the study is less concerned with the size of an individual's network, but is more interested in the types of helping behaviour provided between individuals, and the meanings that young mothers attach to their social networks. The study is concerned with gaining a better understanding of how social support operates in particular contexts and why; what roles it fulfils, and how it can help young women to cope with pregnancy and motherhood. An understanding of these factors is important for conceptualising social capital in the lives of teenage mothers.

Quantitative approaches would not be appropriate or sensitive enough to gain information on, or shed light upon the subtle nuances of individuals perceptions, stories or experiences required to gain a proper understanding of the function of and meaning of social support in young mother's lives. Quantitative approaches may have been able to provide data in relation to the size or composition of networks in relation to some form of outcome measure, but this would have provided a limited understanding of individuals' interactions with each other and the nature and meaning of social support in the context of mothers lives. It is important to explore the context and processes of social capital as it is such a complex and contested concept (as explored in Chapter 3), and as such is conceptualised differently by many different theorists. Qualitative methods allow for this theoretical complexity to be recognised.

Qualitative research engages in exploring dimensions of the social world in understanding the everyday lives and experiences and imaginings of research participants, the ways that social processes, institutions and discourses or relationships work, and the significance or meanings these might generate. This is achieved through methodologies that encourage richness, depth, nuance, context, and multi-dimensionality. This means it has an unrivalled capacity to constitute compelling arguments about how things work in particular contexts (Mason, 2002). Qualitative research can be grounded in a philosophical position that is broadly 'interpretivist' in the sense that it is concerned with how the social world is interpreted, understood or experienced, and will see at least some of these as meaningful layers in a complex social world (Mason, 2002).

Mason (2002) argues that when designing a study some properties appear to be more well matched to qualitative research methodologies than others. For example, social processes, interpretations, social relations, social practices, experiences, understandings, seem particularly so. The understanding of this

has important implications in terms of adopting a particular ontological perspective (Mason, 2002).

Epistemology is concerned with the philosophical consideration of working out what counts as evidence or knowledge (Mason, 2002). This research has adopted a position that an individual's perspectives, attitudes and experiences and the interpretations of these can provide evidence that will answer the original research objectives related to social processes. This links directly back to the ontological position taken that such social processes exist and can therefore be studied in order to increase our knowledge of the social world. Therefore the epistemology helps to generate knowledge and explanations about the ontological components of the social world, such as the perspectives and experiences, and social processes that I have argued are central to this research and outlined in the research aims and objectives. By considering the role of social support networks and social capital in alleviating the affects of social exclusion, I am adopting an ontological position which sees institutions, organisations, and structures, as well as individuals, as meaningful components of the social world. For example, in my current job within Public Health I have experienced how wider structures within society from very local level services such as the police, schools and clinics etc through to national institutions and high level government policy are completely intertwined with how individuals experience life, and as such can not be explored in isolation. In terms of epistemology each of these different research topics is suggesting that distinctive dimensions of the social world, such as perspectives, are knowable.

5.1 Interpretivist approaches

This study has embraced an interpretivist approach throughout its design. Mason (2002) argues that most qualitative researchers would reject the idea that a researcher can be a completely neutral collector of information about the social world. Instead, the researcher is seen as actively constructing theories about the world according to certain principles derived from their epistemological

position. Interpretivist approaches are distinct in that they see people, and their interpretations, perceptions, meanings and understandings, as primary data sources. This approach will support research where the aim is to explore people's individual and collective understandings, perspectives, social norms etc (Mason, 2002).

Interpretivists are concerned with understanding the social world that people have produced through their ongoing activities. This everyday reality consists of the meanings and interpretations given by people to their actions, other people's actions and their social situation. In order to understand the world people have to interpret their activities together, and it is these meanings that constitute their social reality. So an interpretivist approach not only sees people as a primary data source but also seeks their perceptions of the 'insider view' (Mason, 2002). The study embraces a perspective that suggests there is no one truth regarding social reality, but that the data collected through individual's accounts of what has happened to them, and the interpretation of this, is one version of reality, rather than a belief that reality is objectively 'out there' as a set of social facts which are waiting to be discovered.

5.2 Using mixed data sources

Mason (2002) argues that what you see as a potential data source, or what you see as a method of generating relevant data, will depend upon your ontological and epistemological positions. This required the consideration of what could young mothers as individuals, and what could service providers within organisations, tell me, and which phenomena and components of social reality could these data sources help to address. Through this consideration the conclusion was reached that young mothers themselves, as well as those providing services for young mothers would be best placed to gain relevant and meaningful data, using methods that yield in-depth, rich data.

It is possible to approach the research aims and objectives from different perspectives (young mothers and service providers). Both these groups were treated as equally valid sources of evidence, as well as on the basis that the two methods yielded comparable data. The two data sets can be considered to be authentically consistent, as they are based on similar, complementary assumptions about the nature of phenomena being studied, in that they can be best be explored through qualitative interview data.

The differing data emanate from the same epistemologies, or are at least complementary epistemologies. They are based on similar assumptions about what can legitimately constitute knowledge or evidence. Both data sets were based on the evidence of individuals telling of their experiences and perspectives or interpretations. The different data sources provide a wider range of perspective and balance.

5.3 Introduction to the empirical work

Salford was selected as the setting for the study because it is a city with a high teenage pregnancy rate relative to the national average (as discussed in chapter 1). For this reason setting the study within Salford gave access to a diverse mix of young mothers with a range of characteristics, and therefore was able to provide an appropriate population which could be drawn upon to best address the research objectives. Salford City Council and PCT have both highlighted a reduction in teenage pregnancy as a public health priority, and have produced local strategies for dealing with the issue. Situating the study in Salford gave the best opportunity to capture the experiences of young mothers vulnerable to social exclusion because of the poor socio-economic status of the city in relation to the UK average (Salford was placed 12th most deprived out of 354 local authorities in the IMD, 2004). Because the city has such a high teenage conception rate, and because of the relative poverty experienced within the city, Salford was selected by the government as one of the areas within the country to receive additional services for young mothers in the form of Sure Start Plus, or

the Teenage Pregnancy Team. As a result of this, Salford was an excellent example of a city with the full range of formal social support services available to young mothers, in order to explore how the formal services may constitute a source of social capital.

This study has not based the analysis on data derived from a sample that is statistically representative of the wider population, and is therefore not attempting to make any empirical generalisations. Nevertheless there is no reason to assume that the sample used or the analysis are not atypical in any way. Salford could be considered to represent an appropriate city within which to explore early motherhood, from which the findings may be theoretically generalisable and will inform understanding about early motherhood and the role of social networks in other similar contexts.

The empirical work presented in the following chapters was undertaken within the city of Salford. Data was collected from two groups; the providers of specialist services for young mothers, and young mothers themselves (table 6).

Table 6 – Summary of methodological approaches for all stages of the study

	Phase 1	Phase 2 - Antenatal	Phase 2 – Post Natal
Sample	Interviews with 10 members of staff representing 7 different services providing specialist support to young mother or pregnant teenagers	18 pregnant young women aged 19 or under living in Salford	10 young mothers living in Salford
Location	Interviewees workplaces/ service locations	Antenatal clinic, Salford Royal Hospital	Participants' homes
Data collection tools	Semi-structured interview guide based on Barrera's ISSB	Semi-structured topic guide in order to carry out depth interviews	
Method of analysis	Spreadsheet for closed, structured questions Framework qualitative data analysis for the semi-structured interview data	Spreadsheet for closed, structured questions Framework qualitative data analysis for the semi-structured interview data	

5.4 Exploring social support using qualitative interviews: Data collection and development

The second phase of the study addressed research objectives through in-depth, semi-structured interviews with young mothers before and after they gave birth.

Forbes and Wainwright's (2001) research highlights the limitations of survey-derived data and the challenges of using such data to develop complex social explanations for health inequalities. They argue that concepts such as health inequality and the related concepts of 'social isolation' and 'social support' would benefit from methodology that would provide a more in-depth insight into the causes of health inequalities.

Rather than focusing on a specific issue related to teenage pregnancy a conversational interviewing method to obtain rich narrative data was adopted. By

drawing on methods described in Humphrey's (2001) research, the participants were encouraged to tell their stories during interviews, offer their insights and illustrate their experiences with examples. This approach was felt to be particularly appropriate due to the topic of the research, as it was exploring the major transitions and life events, of pregnancy and motherhood, which mark principal periods of life when a person takes on a new set of roles (Humphrey's, 2001).

Most qualitative research operates from the perspective that knowledge is situated and contextual, and therefore the task is to ensure that the relevant contexts are bought into focus so that situated knowledge can be produced. Most agree that knowledge is at the very least reconstructed, rather then the facts simply being reported in interview settings. According to this perspective meanings and understandings are created in an interaction, which is effectively a co-production involving the researcher and interviewee. Interviewing therefore tends to be seen as involving the construction of knowledge rather than the excavation of it (Mason, 2002).

Cattell's (2001) research offers a useful grounding for this study as it argues that despite the affinity of the concept of social support with 'community', much of the research on social support and health has involved the use of survey data which poses a limitation in the literature. Cattell's (2001) study takes a comparative approach based on localities, which explores qualitatively the complexity between processes concerned with poverty, disadvantaged areas and health and social networks. Similarly this study takes a locality approach, by exploring the range of support available within a geographical area. Cattell uses a multi-method approach to exploring social support, including qualitative interviewing.

5.5 Perspectives on measuring social support

Measures of support generally fall into two categories – those dealing with the quality or content of the supportive relationship, and those dealing with quantity

and other social network concepts such as size, frequency, density etc. Broadhead et al (1983) argues that it is the quality of social support that is the stronger predictor of health outcome than quantity measures, and that quantity of social support is often not significantly related to well being. This research will focus on the quality and nature of social support rather than network structure, by exploring social support qualitatively to gain an understanding of exactly what elements young mothers find supportive and beneficial to their lives and social inclusion.

Cooper et al (1999) argue that there appear to be almost as many definitions and measures of social support as there are studies of it. Many researchers have been interested in identifying and labelling various types of social support, such as differentiating between 'structural' and 'functional' aspects (Barrera, 1982, House et al, 1988). Structural aspects refer to the quantity of the social network, such as the number of friends and acquaintances and the frequency of contact. Functional aspects of social support refer more to the quality of support and the type of helping/supportive behaviour provided.

Most researchers in the social support literature are in agreement that the larger and more diverse an individual's social network the more access a person will have to functional relationships, and the more potential benefits they will have to good health (Cooper et al, 1999). For example, Berkman (1984) found that an individual's risk of dying of heart disease or cancer increased as the size of their social network decreases; Cohen and Syme (1985) found that the larger and more diverse and individual's social network, the greater their resistance was to the common cold.

Networks can be also be defined in terms of size, geographic dispersion, strength of ties, density/integration, composition and member homogeneity (Craven and Wellman 1973; Mitchell 1969; Walker et al 1977).Likewise, it's important to recognise the nature of the human emotions involved. The size of

the network and the frequency of contact between members are of little value if the interactions are negative and stressful. It is also possible that a single relationship is of greater value in terms of meeting an individual's emotional needs than a large number of more superficial friendships. An individual's subjective perceptions of the network are important in understanding the meaning of the relationships and the strength of emotional ties (House, 1981).

Bowling (1991) asserted that there was no assessment scale which comprehensively measured the main components of social network and support with acceptable levels of reliability and validity (Bowling, 1991). Previous studies relying on single-item questions and crude or simplistic measures, could not be used to derive any substantive recommendations for practice. For this study it is necessary to be able to understand relationships according to their content and process.

O'Reilly (1988) argues that in a review of 33 instruments used to measure social support or social networks, only modest agreement was found in the conceptual definition, and frequently concepts were not defined or ill-defined, meaning validity and reliability were compromised. The paper is critical of the plethora of current research describing the relationship between social support and/or social networks and health status, on the basis that there is a lack of clarity in the definition of social support, and there is a lack of validity and reliability of the measurement instruments. O'Reilly states that studies by Branch and Jette (1983), Carveth and Gottlieb, Marmot (1982), Miller et al (1976), Pearlin et al (1981) and Vachon et al (1982) all fail to provide any information relating to the validity or reliability of the social support measures used. Similarly 13 of the 33 studies reviewed failed to provide a conceptual definition of social support, including studies by Andrews et al (1977), Oxley et al (1981), and Williams et al (1981).

Theorists such as Sherbourne and Stewart (1991), Weiss (1969) and Barrera (1982) take a more multidimensional approach to understanding social support, rather than focussing purely on network structure. Sherbourne and Stewart (1991) distinguished five categories of social support:

1 Providing emotional support, love and empathy
2 Providing instrumental or tangible support
3 Providing information, guidance or feedback on behaviour
4 Offering appraisal support which helps the person to evaluate themselves
5 Giving companionship in leisure and recreational activities

Weiss (1969) outlines six major functions of social relationships, which encompasses most of the functions proposed by other commentators:

1. Intimacy: The provision of an emotional climate where individuals can express their feelings freely
2. Social integration or sense of belonging: The provision of a sharing experience, information and ideas or concerns
3. Opportunity for nurturing behaviour: Occurring in relationships where a person takes responsibility for the well being of another
4. Reassurance of worth: To promote an individual's competence or worth in a role
5. Assistance: The provision of tangible goods (food, money) or task orientated services (transportation, cooking)
6. Guidance and advice: Communicating advice or appraisal of a situation

Barrera asserts that social support appeared to be a variable that was capable of having a broad impact on the well being of community residents, but was portrayed as a ubiquitous and indistinctly defined concept. There are various approaches designed to measure social support, but few of these measures have been systematically developed and repeatedly used with different populations (Barrera, 1982). The diversity of tools to measure social support

illustrates the mutli-faceted nature of the support in that some measurement approaches have focused on the providers of support, some on an individual's subjective appraisal of support, and others on activities involved in the provision of support.

Barrera (1982) states that in addition to social network analysis there are two other approaches to assessing social support. A second approach to assessing support consists of methods that emphasise the individual's subjective appraisal of relevant support; this uses qualitative indices to capture concepts such as satisfaction with support. Cobb (1976) agues that social support is essentially "information" that an individual is loved, esteemed and part of a network of communication and mutual obligation.

A third approach to assessing social support is concerned with behavioural activities that are expressed in natural forms of helping. When compared with qualitative and quantitative measures of the presence of significant social relationships, attempts to assess natural helping behaviours have been rare. Previously, social support research largely consisted of the investigation of social support systems and structures rather than 'what they actually do, how and with what results'.

Therefore Barrera asserts that in recognising the multifaceted nature of support, it would be a distinct advantage to incorporate a multi method approach to assessing support, rather than a single approach. Previous studies, which identify social support network members typically request respondents to simply list people who are significant or important to them. Barrera (1982) argues that whilst this helps to identify social importance networks, it fails to identify specific supportive functions. The qualitative indices of support prove to be the strongest predictors of symptomatology (Barrera, 1982).

The Inventory of Socially Supportive Behaviours (ISSB) is a measure designed by Barrera (1982) for use within a wide range of community populations. Social support was conceptualised as the diversity of natural helping behaviours that individuals actually receive, derived from previous literature on social support. It was felt that most existing scales concentrated on the structure of the network rather than what the members actually did, especially in view of the noted discrepancies between actual support provided and subjective perceptions of support.

The ISSB measures four types of support: emotional, instrumental, information appraisal and socialising. The inventory asks respondents to state how people have helped them in the last month and to respond on a five point Likert-type scale to each on the 40 items as 'not at all', 'once or twice', 'about once a week', 'several times a week' or 'about everyday'. Examples of items include:

Items on whether anyone has given you support:

- Expressed interest and concern in your well being
- Listened to you talk about your private feelings
- Was right there with you (physically) in a stressful situation

Items on instrumental appraisal support:

- Provided you with a place where you could get away for a while
- Provided you with transportation

Informational appraisal support:

- Gave you some information on how to do something
- Gave you feedback on how you were doing without saying it was good or bad
- Helped you understand why you didn't do something well

Socialising:

- Talked to you about some interest of yours
- Did some activity together to help you get your mind off things

To summarise, there has been little attempt to test measures of social support for reliability and validity. Existing research generally suffers from methodological problems: imprecise definition, failure to treat social support as a multidimensional concept, and various intervening variables confound studies. The main problem with most studies has been that they measure only the structural rather than qualitative aspects of social support. Conceptual definitions of social support are many and varied and lack in consistency.

Whilst previous research has been useful in highlighting the relationship between social support networks, social inclusion and health for young mothers, it also reveals a lack of research in this area which examines the content or nature of social support that is available to young mothers through formal services and how it can increase social inclusion. Although this literature provides a useful insight into possible methodologies for this study, none provide an exact method that could be replicated in order to answer this particular research question.

What was required was to develop a structured framework for analysing social support provided formally that was able to consider the whole range of service provision for teenage parents within the city to create a holistic picture of the support available to teenage mothers, rather than examining organisations in isolation. Given the extensive critique of measures of social support, and a lack of literature concerned with measuring the quality of formal social support, it was essential to identify a measure that could be adapted to most appropriately answer the research question i.e. the nature of social support provided by a range of services.

5.6 Empirical work: Development of data collection: Phase 1

By exploring the literature around the differing theoretical perspectives on measuring social support, it became clear that Barrera's method of categorising socially supportive behaviours would be the most appropriate tool to use for this particular study as it explored the quality and nature of types of socially supportive behaviours available, rather than just structural characteristics such as quantity and geographic dispersion. This was essential in order to gain a proper understanding of what was available to young mothers. Barrera's model was also the tool that was found to be the most applicable for use with service providers, rather than just with young mothers. In particular one of the most interesting features of Barrera's model of social support was that it was originally developed to measure social support and adjustment in adolescent mothers, which would presumably make it particularly applicable to this study.

Barrera's (1982) model was developed for use with individuals and focusses on types of supportive behaviours, rather than proxy measures of supportive activities, or the individual's perceptions or feelings about how they rate the support they receive. Therefore, the character and design of the scale made it possible for it to be appropriately adapted to formulate a semi-structured interview schedule to map the nature of formal social support available to teenage mothers provided by local services. By adapting Barrera's model in this way to use as the basis for the semi structured interview schedule, the study provides a tool for investigating qualitatively a whole spectrum of socially supportive behaviours provided by services within a structured framework, based upon a well established theoretical perspective. An evaluation of the ISSB showed it has high internal consistency and test-retest reliability (Gjerdingen et al, 1991).

As Barrera's model was devised for use with those who receive support, rather than those who provide support, the questions needed to be reworded in order for it to be appropriate for use with service providers. An additional category was

added to the interview schedule which was concerned with the background arrangements to accessing the service, such as how the service was provided, how many sessions were young people able to attend etc. and other practicalities (which can be seen in section one 'Background to the service' on the interview schedule, in appendix 1). An interview schedule was adapted from Barrera's (1982) ISSB. The questions were based around the ISSB's four types of support: emotional, instrumental, information appraisal and socialising (see appendix 1).

5.7 Sampling and recruitment

A purposive sampling procedure was employed, as organisations were invited to be included in the study based upon the specific characteristics that the study was interested in exploring in relation to the research question (Silverman, 2001). The inclusion criteria were as follows:

- Formal service provision – this could be statutory or voluntary sector
- Provision of some form of specialist service for young mothers/pregnant teenagers
- Based within the city of Salford

The organisations that were invited to take part in the study were identified through a series of planning meetings with the city-wide Teenage Pregnancy Co-ordinator. There is no way of being entirely certain that every single organisation or group was included in the study, but the services that were included were identified as being the main services that were known to the Primary Care Trust and the city-wide Co-ordinator as having some kind of specialist remit around supporting pregnant teenagers or young parents. The organisations included in the study had a wide range of differing remits including housing, education and training, health, social care, advice and advocacy, which were their main purpose as organisatons, however all the services offered specific support for young mothers in addition to their main function. The Teenage Pregnancy Team was unique in being the only organisation whose sole purpose was to work with

teenage mothers, with a completely broad remit. All the organisations that were invited to take part in the study accepted.

5.8 Procedures

Data for phase 1 of the study were collected from a series of semi-structured interviews with service providers to explore the nature of support that was being offered by services to pregnant teenagers and young mothers.

In the first phase of the study, face-to-face interviews were undertaken using a semi-structured interview schedule or modified ISSB. Semi-structured interviews utilise techniques from both focussed and structured methods. Questions are normally specified, but the interviewer is free to probe beyond the answers in a manner that would often seem prejudicial to the aims of standardisation and comparability. Information about age, sex occupation and so on can be asked in a standardised format. Qualitative information can then be recorded by the interviewer, who can seek both clarification and elaboration on answers given. Semi-structured interviews are said to allow people to respond more on their own terms than standardised interviews, but still provide a greater structure for comparability over the focussed interview (May, 1993).

Data were collected over a six month period in 2004. There were seven separate organisations included in the study. In most cases only one staff member was interviewed, except in the case of Sure Start Plus, where four staff members were interviewed each with a different role, as this was the leading service provider for young mothers. Members of staff were selected from within the other organisations if they had a role in providing support that was specific to teenage mothers. The service manager from each organisation was contacted initally by letter, and a follow-up phone call. They identified who within the organisation would be the most appropriate person to be interviewed; participants included three service managers, two clinicians, and five project workers/officers. Interviews took place at interviewees workplaces, but in all

cases took place within private offices and were undisturbed. Interviews lasted between half an hour and an hour. Where participants agreed, interviews were recorded and then later transcribed. However in the three cases consent was not given to tape record the interview, notes were taken during the interview and written up in detail straight after the interview had finished.

5.9 Procedures and data collection – Phase 2

This phase used in-depth interviews with a sample of 18 pregnant women aged 19 and under, which took place between 2004-2007. Interviews took place in a private room within the antenatal clinic or in women's homes depending upon each woman's individual preference. After seeking each individuals consent, each interview was tape-recorded and transcribed verbatim. No participants declined to have the interview recorded. Each interview lasted approximately one hour.

The interview was structured around a topic guide in order to ensure that all the differing sources of social support identified in the ISSB were covered systematically within each interview (see appendix 2). In addition participants were asked a number of structured/ closed questions relating to their age, the number of weeks pregnant they were, and their tenure and ethnicity.

5.10 Sampling and recruitment

As with phase 1 of the study, the participants were recruited using a method of purposive sampling. Purposive sampling is concerned with choosing participants because they illustrate some feature or process in which we are interested. Purposive sampling requires the consideration of the parameters of the population that we are interested in and choosing our sample case carefully on this basis.

In this study the characteristics of the sample included age, and pregnancy status (females aged 19 or under who were pregnant). The sample were

recruited through attendance at an antenatal clinic within a hospital. This is because the purpose of purposive sampling is not to establish a random, or representative sample drawn from a population, but rather to identify specific groups of people who either possess characteristics, or live in circumstances relevant to the social phenomenon being studied. Participants are identified because they will enable exploration of a particular aspect of behaviour relevant to the research. This approach to sampling allows the researcher deliberately to include a wide range of types of participants and also to select key participants with access to important sources of knowledge (Mays and Pope, 1995).

Participants were recruited by directly approaching young pregnant women who were attending for antenatal appointments at Salford Royal Hospital Trust and asking them whether they would consent to take part in an interview (whilst waiting for their appointment). Initial interviews with the young women took place over a period of seven months. It took a significant amount of time to recruit the required number of participants to achieve saturation of data, as they were recruited by waiting at the antenatal clinic for whichever women may have had appointments that day, who were aged 19 or under. It was then dependent upon their consent as to whether they would take part in the study, however only one woman declined to be interviewed, whilst the further 18 consented to take part in the study.

It was possible to access Salford Royal Hospital Trust and therefore the sample through initial contact with the Teenage Pregnancy Team from the first phase of the study, who were based within the hospital. However there was a rigorous process to complete in order to gain Clinical Governance approval within the maternity department, which is explained in more detail in the Researcher Reflexivity section later on.

In order to recruit the young women to the study, each morning in the antenatal clinic the receptionist would print a list of all the women who had been invited for

appointments that day, the list also included each woman's date of birth. The list enabled the identification of any women who were expected to attend that day who were aged 19 or under. The researcher could wait until they arrived at the clinic and then approach them about taking part in the study. This process was extremely time consuming as the clinic was held on a weekly basis and some days no women aged 19 or under would have appointments, other days there would only be one or two, possibly with a 3 hour wait between each attendance at the clinic. Although this process was laborious, it had benefits in terms of reducing potential bias.

It was planned that each respondent would then receive a further follow-up depth interview approximately 1 year later. The purpose being that it would be possible to study young mothers social support experiences longitudinally, in order to identify changes in these experiences before and after child birth. There needed to be sufficient time between the two interviews for the young women to have given birth, and to have had, at least, a few months experience of motherhood. However in reality this proved to be much more difficult, as over three-quarters of the participants (n=14) became lost to follow-up. Perhaps this should have been anticipated during the original study design, but is an interesting topic for discussion and is explored in more detail in section 10.3.

A range of solutions were put forward to rectify the emerging problem with the study design, including studying the remaining four participants in more depth, as case studies. However this idea was eventually discounted, as it was felt that it would not be a robust enough method of data collection to answer the original research question or to shed light on the social support experiences post-natally and would have also allowed for attrition bias as those young women included followed up in the study may have been those who led more stable lives.

It was then decided that a new sample of young mothers needed to be sought. This decision was also not without its problems. Firstly finding the sample was

arduous and time consuming. Six new young mothers were recruited with the help of the health visiting team, who collected consent from the women and then passed their contact details on to me to arrange the interview. Secondly, the decision to recruit a new sample meant that the results would no longer be longitudinal in nature, i.e. it would not be possible to draw any conclusion from the data in terms of following individual women through their life events. However, more positively, the recruitment of the new sample allowed for the exploration of the experiences of young mums post-natally, which was one of the most important areas of the original research objectives, and would help to address the potential attrition bias within the remaining members of the original sample.

To recruit the new sample the local health visiting team went through their case loads to identify mothers aged 20 or under. If the mum agreed, then her contact details were passed on to the researcher to make arrangements to complete the interview. None of the women whose names had been put forward by the health visitor then declined to be interviewed when approached by the researcher. One of the potential problems with this approach is that there was an opportunity for pre-selection by the health visitors. It was possible that they only approached those women to take part in the study, who they knew to be more obliging, or more likely to agree, which may have led to a lack of representativeness in the sample.

Consequently, four follow-up interviews were undertaken with participants from the original sample of pregnant women, following the birth of their baby, and 6 interviews were undertaken with a new sample of young mothers with children aged under 2 years. The interviews all took place in women's own homes, and lasted approximately one hour. During the follow up interviews with the participants' from the original sample, participants were more talkative, which may have been because there was an increased sense of rapport. Breakwell (1990) states that the validity of information collected is said to improve with

repeated interviews. Talking to someone on several occasions seems to increase the sense of rapport and encourages greater communication and honesty. However, the interviews with the new sample were equally fruitful, in that having had experience of actually being a mother (rather than just experiencing pregnancy as was the case with the initial set of interviewees) the respondents had a wealth of information to share.

It may be considered that the loss of such a large proportion of the original sample to follow up may have an impact upon the validity of the subsequent findings of the study. This would be apparent if the sample of women who were traceable differed in any characteristic from the proportion that were untraceable. For example, the women who were followed up could perhaps be argued to be those with more stable lives and therefore those receiving more support. This was not felt to be the case, as no particular characteristics appeared to be more common amongst the sample that were traceable, all had very differing individual experiences. If the research was compromised in any way because of this methodological problem it was compensated for as much as possible with the inclusion of the new sample. However, much of these methodological concerns may not be as significant with regard to this particular study, due to the overall methodology being qualitative in nature and therefore the pursuit for representativeness was not a fundamental concern. Of greater concern was the need to collect in depth, authentic accounts of the young mothers' experiences.

Professionals and young mothers taking part in the study were assured that their interviews would be treated confidentially. To guarantee confidentiality any paperwork relating to the study was kept in a secure cupboard and anonymised by removing interviewee's names and introducing a coding system and destroyed after use, in order to comply with the NHS Confidentiality Code of Practice (DoH, 2003). Ethical approval was obtained from the Greater Manchester Local Research and Ethics Committee, the University of Salford Ethics Committee and the Salford Royal Hospital Trust Midwifery Department

Clinical Governance Board. This was particularly important as young, pregnant women, many aged under 16, have been identified as a vulnerable group (DoH, 2001).

The written information was reinforced by a verbal explanation of the research so that participants could give informed verbal consent (appendix 3). At the beginning of each interview the participants were asked if they consented to be interviewed and informed that the interview could be stopped at any time. In this way the participants confirmed that they had read the interview guidelines and understood the purpose and scope of the research.

Department of Health guidelines state that if a young person is given an information sheet with details about the research including information on the purpose of the research and any possible risks, then they can give consent to take part. Young people aged 16-18 years old can give consent in the same way adults can, without their parents being consulted. However, if they are aged under 16 they may still be able to give consent for themselves provided they understand what is involved (DoH, 2001). For this reason each young person approached about taking part in the study received a comprehensible consent and information sheet outlining the details of the study (appendix 3). If requested, the researcher went through the information sheet with the young person answering any queries they may have had about taking part in the study.

All the participants were treated with respect and sensitivity and the interviews were designed to allow the subject to refuse response to any query. If, during the interview, any respondents appeared to become upset due to any issues raised, information available of where they would be able to seek further support.

5.11 Data analysis: methodological approach

The semi-structured interview schedule for phase 1 allowed for qualititiave analyis and also provided the opportunity to provide a quantitative descriptive

summary of responses to certain aspects of the schedule. It was possible to precode the closed questions relating to the background of how the service was delivered, for example, or aspects of the service that could be quantified such as:

- How many members of staff dedicated to teenage pregancy
- Referral arrangments
- How long the service has been available
- Average length of an appointment
- How often the young person can access the service
- Type of service delivery e.g. one-to-one appointments

The open questions gave the respondent a greater freedom to answer the question in the way they interpreted it. These were analysed by reading through the responses to particular questions, and systematically coding them and drawing out common themes. The data collected from broader open-ended questions were then coded and analysed using an established qualitative data analysis process. To some extent the data was already quite organised as the quesions had been structured around the ISSB, which meant that the data was already coded into the broad categories of: emotional, instrumental, informational, socialising support. However more detailed analysis was undertaken on the qualitative aspects of the data using Framework Analysis (Richards and Richards, 1994). This will be explained in more detail later in the chapter.

Tesch (1991) has identified a range of different approaches to qualitative data analysis. The first approach is based on language: discourse analysis, symbolic interactionism and ethnomethodology. Second there is a 'descriptive or interpretative approach', which seeks to establish a coherent or inclusive account of a culture from the point of view of those being researched, such as classic ethnography and life-history studies. Finally, there are theory-building

approaches, where the generation of theory is the primary goal, such as grounded theory.

Firstly, discourse analysis was considered as an approach to the data analysis for this study but this was eventually discounted for a number of reasons. Discourse analysis focuses on talk and texts as social practices, with a focus on issues of accountability, looking at the way people manage issues of blame and responsibility (Antaki, 1994; Potter, 1994; Gill, 1996). Discourse analysis has been used extensively as a qualitative research method. However Potter (1996) argues that what this misses is that, first, discourse analysis is not just a method but is a whole perspective on social life and its research, and, second, that all methods involve a range of theoretical assumptions. In relation to the use of discourse analysis with qualitative interview data, Potter (1996) asserts that traditionally the goal of an interview is to produce a piece of colourless, neutral interaction. However in practice, interviews are as complex and vivid as any other type of interaction, and responses to answers, which may seem neutral and non-committal may have an important impact on the trajectory of the interaction.

In discourse research, interviews have been used extensively because they allow a relatively standard range of themes to be addressed with different participants which is more difficult to achieve from naturalistic approaches such as transcripts of conversations or recordings of counselling sessions, or newspaper articles. These settings are made up of natural interaction in the sense that it is not 'got up' by the researcher. Potter (1996) states that the test is whether the interaction would have taken place, and in the form that it did, if the researcher had not been born. Clearly this is not the case with this study, whereby service providers, and later young mothers, were made aware of the purpose of the interviews, so they in no way could be considered to be natural interaction.

Potter (1996) argues that using interviews in discourse analysis can be problematic in that the interaction can become swamped by the interviewer's own

categories and constructions. Even the most open ended of interviews is guided by a schedule, which specifies topics and themes as important. In addition, even when an interview is understood as an interaction in its own right, the nature of the structure of an interview in terms of its dominant question and answer format is not ideal for getting at the sorts of turn-by-turn display of action and understanding that discourse analysts uphold. Partly for these reasons, discourse analysis is becoming increasingly applied to the study of records of natural interaction.

Another distinctive feature of discourse analysis is the focus of the analysis being concerned, not with the simple rendition of words within an interview but on features such as corrections, hesitations, pauses and intonational features. In addition to this discourse analysts tend to present extensive amounts of 'raw' data to their readers to draw their own conclusions. This differs from ethnographic interview work whereby interpretations are taken on trust, and the data is largely pre-coded and pre-theorised.

In line with the research paradigms described earlier taking an interpretivist position would require searching the data for, and organising them into, relevant interpretive categories or themes. This would require the development of systematic and transparent mechanisms for arriving at these interpretations and for drawing on lay interpretations.

Qualitative data analysis is about detection, and the tasks of defining, categorising, theorising, explaining, exploring and mapping are key roles. This research can be considered to be concerned with defining concepts of and mapping the range of social support, within Phase 1, and with finding associations and seeking explanations in Phase 2 of the study. Therefore it was essential to find a method/s of data analysis that would support these differing functions.

There are many documented methods of qualitative data analysis (Bogdan and Birklen ,1982, Tesch , 1991, Bryman and Burgess, 1994,). Bogdan and Birklen (1982) provide a useful list of categories that can be used for developing coding frameworks. However, these coding suggestions provided a helpful starting point to begin thinking about organising the data. In reality they did not appear to be particuarly applicable to the data in this study. The coding suggestions put forward by Bogdan and Birklen (1982) felt less applicable to a semi-structured interview methodology, such as this study, and more appropriate for more in depth ethnographic methods of collecting data over a long period of time, such as with covert observation for example.

Various methods for thematic analysis are also described in Bryman and Burgess (1994), Glaser and Strauss (1967), Richards and Richards (1994), Rose and Sullivan (1996). However a method of qualitative data anaylsis called 'Framework Analysis' developed by Richards and Richards (1994) was found to be particuarly applicable to this study. 'Framework' is an analytical process which involves five key stages to qualitative data analysis:

1. Familiarisation
2. Identifying a thematic framework
3. Indexing
4. Charting
5. Mapping and interpretation

The 'Framework' method of qualitative analysis was found to be particularly useful to the data analysis within this study, as it has been designed to facilitate systematic analysis within the demands and constraints of applied policy research. This method of qualitative analysis has been argued to have the following key features: dynamic, systematic, comprehensive, and accessible in terms of the interpretations that are made by the researcher (Richards and Richards, 1994). From researching methods of qualitative data analysis in the

literature 'Framework Analysis' appeared to be the most practical and comprehensible method, and a method that seemed possible to operationalise with the data within both phases of this study.

5.12 Applying Framework analysis: Phase 1

To explain the process in more detail, the analysis involved the research familiarising herself with the transcripts by reading through them on numerous occasions in order to become absorbed in the data, and completely familiar with the content of each individual interview.

Whilst undertaking this process draft list of emerging codes was recorded. The list of codes were then written up and then rechecked against the transcripts in their original format in order to ensure that no themes had been missed, or to look for any discrepancies or anomalies. This final set of codes then formulated the thematic framework.

Following this, the process of 'indexing' and 'charting' included exploring the data again and assigning codes to individual paragraphs or statements. It was possible to return once more to the original transcripts and coded the data accordingly and physically moved it into the appropriate themes, which constitutes stage 3 and 4 of the Framework Analysis process. To some extent the data was coded or at least ordered in some way as the interviews had been structured around Barrera's four types of social support, however, this was not an exhaustive list of codes, and new themes emerged. It was important to use Barrera's social support categories as early codes as Minichiello et al (1990) state that the codes you devise should be related to the research questions asked and fit into a conceptual scheme, which it was strongly felt to be the case. In this way, although the main themes constituted the original structure of the interview schedule i.e. Barrera's ISSB categories, a number of new themes emerged such as:

Descriptions of the content or topics covered in the service provision
How the service was delivered and practicalities
Taking a holistic approach
Differing types of instrumental support
Differing types of socialising support
Negative interactions

Some of the emerging themes crossed over or appeared in different sections within the original organisation of the data using Barrera's categories of supportive behaviours, such as with the theme around 'Taking a holistic approach'. When this occurred stage 5 of Framework Analysis began, as it was then necessary to explore these themes in relation to how they linked with, or could be mapped in relation to the different types of supportive behaviours. The most critical part of the analysis was then the 'mapping and interpretation' stage whereby each theme could be explored in more detail, and interpreted or explained. To give a brief example to illustrate from the original transcripts:

"We would discuss with the young person about their interests and help them to access this if they weren't already doing so. Just as an example, if someone said they were really interested in water aerobics then the support worker would help them to find facilities for this locally and maybe go with them for the first session." (Supported Tenancies)

This quotation by a service provider was concerned initially with exploring opportunities for socialising support, however it was also demonstrative of taking a holistic approach in that the respondent, who happened to work for the local social housing provider, would spend time going to a swimming session with one of their clients, if it was to help them over the longer term. This example is useful in highlighting the mapping and interpretation of the data, as outlined in the Framework Analysis process.

5.13 Applying Framework analysis: Phase 2

Following the review of the literature on methods for qualitative data analysis described in the Phase 1 study, it was decided that Ritchie and Spencer's (1994) Framework Analysis, would again be the most appropriate tool for analysing the data collected in the Phase 2 study as it had been found to be so useable and systematic when applied to the analysis of the qualitative data in the Phase 1 study. However due to the large quantity of qualitative data collected in Phase 2 it was decided that although Framework Analysis would be the principle method of analysis this process would be assisted by the use of a Computer Aided Qualitative Data Analysis Package (CAQDAS).

The first analysis of the data, using the CAQDAS package NVivo was coded using a series of recurring topics based around sources of social support such as friends, family, partner, community, groups, services provider etc. However this analysis of the data on its own failed to provide a sufficient insight into the complex experiences of participants and the relationships between different phenomena. As a result of this the data was completely reanalysed using a new coding framework.

Further exploration revealed that much has been written both promoting and condemning the use of CAQDAS. Bryman (2004) described the process of using Nvivo to code qualitative data. The computer takes over the physical task of writing marginal codes, making photocopies of transcripts, cutting out chunks of text relating to different codes, and pasting them together. This could be considered to be stages 3 and 4 (Indexing and Charting) of the Framework Analysis process. CAQDAS does not automatically do this for the analyst; the analyst must still interpret the data, code and retrieve it.

It has been suggested that CAQDAS reinforces the tendency for the code-and-retrieve process that underpins most approaches to qualitative data analysis to result in a fragmentation of the textual materials on which researchers work

(Weaver and Atkinson, 1995). As a result the narrative flow of the interviews may be lost. It has been argued that the fragmentation process of coding text into chunks that are then retrieved and put together into groups or related fragments risks decontextualising data. Having awareness of contact is crucial to many qualitative researchers and the prospect of this element being sidelined is not an attractive prospect. However, from the experience of this study it has perhaps highlighted problems in my original coding strategy, rather than shortcomings in the CAQDAS software itself.

It is sometimes suggested that CAQDAS enhances the transparency of the process of conducting qualitative data analysis. It is often noted that the ways in which qualitative data are analysed are unclear in reports of findings (Bryman and Burgess (1994). Using CAQDAS may force researchers to be more explicit and reflective about the process of analysis.

The 'Framework' method of qualitative analysis was found to be particularly useful to the data analysis within this study, as it has been designed to facilitate systematic analysis within the demands and constraints of applied policy research. To explain the process in more detail, stage one of the analysis involved reading through the transcripts on numerous occasions in order to ensure complete familiarity with the content of each interview, and to become absorbed in the data. Once this was achieved it was possible to begin to tentatively jot down ideas for codes, dependant upon the content of each interview. These ideas could be topics that were occurring in the text, different sources of support, different types of supportive behaviours, or less tangible items such as feelings of stigma, feelings about emotional well being. Following this it was necessary to reread through all the transcripts a few more times in comparison to the draft list of codes that had been produced, in order to identify any codes that may been have missed, or to identify any discrepancies, to ensure a rigorous and systematic process of analysis. This took a considerable amount of time, as it consisted of returning to the transcripts to actively search for

responses that differed from the developing themes. Once sure that the list was exhaustive, the list then became the thematic framework for the analysis of the data, stage two of the process. Atkinson (1992) describes the coding of transcripts as a well-established process of exploring the data for categories and instances.

For stage three of the Framework process, the thematic framework was used to code the different sections within the transcripts, and then physically moved the extracts around into separate files. Many of the extracts frequently had to be coded with two or more different codes, and then copied and pasted into all the appropriate categories. Initially the data was broken down according to the different types of social support in the Barrera model, but there was too much overlap between participants' accounts. It was therefore more reasonable to analyse the data in terms of the sources of social support initially, and then into types of helping behaviour, and then any new key themes or sub themes that were identified as being significant within the thematic framework.

Silverman (2001) argues that theoretically defined concepts can drive good qualitative research and can be very helpful in organising data for analysis. They are also useful to help develop analysis of field data after a research problem has been clearly defined. For this reason, using Barrera's model from the outset to structure the interview schedule will have helped with the analysis further down the line in terms of helping to organise the data in preparation for analysis. However Silverman also highlights that coding schemes and predetermined theoretical concepts can have the disadvantage of deflecting attention away from uncategorized activities. For this reason, although Barrera's model formed part of the thematic framework, an extra effort was made to return on a number of occasions to the original transcripts to identify new emerging themes not outlined in the original theoretical model.

Coding and indexing the data did not always take place in a linear fashion, but involved revisiting the original transcripts often to identify new categories and to try and understand the links between categories. Initially the two data sets (post and antenatal) were analysed entirely separately. After this, it was possible to link the two sets of interviews (post and antenatal) and any new emerging themes relating to changes over time, or differences in the experiences of the participants at the two different stages. Each interview was read through a number of times and emerging themes were listed with subcategories within each of these. After this it was possible to merge some of the categories. The figure 1 below not only outlines the coding schedule, but also attempts to illustrate the links between categories and subcategories, and therefore to link key themes.

Figure 1 Coding Framework

Informal Sources - Key themes	**Types of support**	**Sub themes**
Families	Emotional support Informational support Instrumental support	Financial support Childcare
Mums		
Partners		
Friendships	Socialising support	
Communities		
Life Changes		

Formal Sources – Key themes	**Types of support**	**Sub themes**
Emotional well being	Emotional support Informational support	
Depression		
Medicalisation		Breastfeeding
Antenatal/parenting classes		
TP Team	Instrumental support	Financial Material Childcare
Housing		
Social Services		
Stigma		
Opportunities for the future		

The most critical part of the analysis was stage five; the 'mapping and interpretation' stage, whereby each theme could be explored in more detail, and interpreted or explained. The relationships between the themes almost felt three-

dimensional, which may help to explain why it was necessary to, in effect, start all over again after the first coding and analysis of the data failed to pick up on the quality and depth of the data that had been collected. This stage of the analysis involved trying to understand the links between and across themes.

Interpretation of the data involved exploring the newly organised data for commonalities, anomalies and patterns, and trying to understand the stories beneath the text, and to take into account the latent content of the interviews. Rose (1982) makes an important distinction between participant concepts and theoretical concepts. Participant concepts are created by informants and couched in their every day language. Theoretical concepts are created by myself and not immediately recognised by the informants as part of their terminology. This was considered to be of particular importance in this study, where by the participants would often speak in words pertaining to young people's culture, which could be used to cover up the actual intensity of their feelings on a particular topic.

Social process, social change, social organisation, and social meaning, require an understanding of depth and complexity in people's situated or contextual accounts and experiences, rather than a more superficial analysis of surface comparability between accounts of large numbers of people. The analytical principles I developed were conceptual rather than straightforwardly empirical, and inductively generated through the data.

5.14 Issues of reliability and validity

Some of the theoretical issues relating to reliability and validity in qualitative research will now be explored in relation to the research practice in this study. In his book Interpreting Qualitative Data, Silverman (2001) explores concerns over the reliability and validity of much qualitative research. Silverman argues that 'authenticity' rather than reliability is often the issue in qualitative research, the aim being to gather an authentic understanding of people's experiences.

Qualitative interview studies are often conducted with small samples and the interviewer-interviewee relationship may be defined in political rather than scientific terms.

As qualitative research, by definition, is stronger on long descriptive narratives than on statistical data, concerns arise over reliability and how the researcher goes about categorising the events of activities described.

"*Reliability refers to the degree of consistency with which instances are assigned to the same category by different observers or by the same observer on different occasions.*" (Hammersley, 1992).

However other qualitative researchers argue that a concern with reliability only arises in response to the quantitative research tradition, where there is considered to be no difference between the exploration of the natural and social worlds. Conversely, it is argued that once we agree to treat social reality, as constantly in a state of change, then it makes no sense to become preoccupied about whether qualitative research instruments measure accurately (Silverman, 2001). Despite this point of view there are practical measures that can be taken to increase the 'truthfulness' of qualitative research.

Silverman (2001) states that the methods used in qualitative research are based upon a belief that they can provide a deeper understanding of social phenomenon than would be obtained by purely quantitative methods. This suggests that there are areas of social reality that statistics cannot measure. Therefore, qualitative researchers suggest that we should not assume that techniques used in quantitative research are the only way of establishing the validity of findings of qualitative research. For example in this study, one of the methods used to contribute to establishing the validity and reliability of the study was the student/supervisor progress meetings. During the course of the data analysis regular feedback was received from the supervisors, who were

themselves familiar with the interview transcripts. This process allowed for agreement that the main themes had been identified. Also the feedback that was received from the supervisors led the researcher to return to my original transcripts and recode the data using a different method, as described earlier.

From a positivist point of view, the aim of interviews should be to generate data, which hold independently of both the research setting and researcher or interviewer. One way in which this could be achieved is by attempting standardisation of the interviews. This point of view would suggest that unstructured interviews are inherently unreliable research instruments. However open-ended or unstructured interviews have the benefit of being more flexible and allow for more intensive investigation of perceptions and feelings.

Silverman (2001) argues that, even more important for the reliability than the type of interview selected, is the need to follow a standardised protocol. For example, each interviewer should ask each question in precisely the same wording and in the same order as outlined on a schedule. They should not show surprise or disapproval of an answer, try to offer explanations of questions, suggest replies or skip questions, which could all lead to bias in the measurement. These practices were employed during this study.

Silverman (2001) asserts that from a constructionist perspective interviews should be concerned with documenting the way in which accounts 'are part of the world they describe'. This means exploring how interview participants actively create meaning, which leads to the idea of 'the active interview'. The implication from this is that guidance that advised on 'good' interview techniques is only appropriate from a positivist point of view. If not, as Silverman argues, we need to recognise that the skills involved in bringing off a successful interview are shared by both the interviewer and the interviewee. Ultimately both points of view are drawing upon the shared properties of commonsense knowledge.

One important point for discussion is whether interviews can be treated as straightforward reports on reality. Clearly interviews can, in principle be treated as reports on external realities, on the condition that strict protocols are in place. From a differing point of view, the condition is that the interviewer should seek to overcome the presumed power imbalance with the interviewee. However, from a constructionist perspective, interviews present data that expresses interpretive procedures or conversational practices present in what both the interviewer and interviewee are doing through their talk and non-verbal actions. This debate is ultimately concerned with whether interview data can be biased.

High reliability in qualitative research is associated with 'low-inference descriptors'. This would include recording data in terms that are as concrete as possible such as including verbatim accounts if what people are saying, rather than the researcher's reconstruction of the general sense of what the participant is reporting, and allowing the researcher's personal perspectives to influence the reporting.

This can be achieved by the following practices, all of which have been addressed in this study:

- Tape recording all face to face interviews
- Carefully transcribing all the tapes to the needs of reliable analysis
- Presenting long extracts of data in your research report.

It has been argued that the qualitative researcher may merely select cases or extracts to present in the analysis, which support their particular argument. For this reason it is important to present the full range of responses, and to explore deviant cases. This issue of consistency can arise because of shortage of space means that many qualitative studies provide readers with snippets of persuasive data extracts. Bryman suggests that it would be helpful to extend transcripts where possible. This argument together with the complaints that much qualitative research is based on anecdotalism are concerned with the question of

validity. Validity is concerned with the truth of the research findings, and how sound the explanations are that are offered. This may be criticised if the researcher makes no attempt to explain contrary cases. Validity is concerned with the extent to which an account accurately represents the social phenomenon that it is exploring.

Deviant case analysis is a further method for testing validity in qualitative research. This method is concerned with actively seeking out and addressing discrepant or anomalous cases. In response to this, when presenting the findings there has been a conscious effort to present the full range of responses given by participants. Not only has the study sought to look for commonalities and themes, but also to explain specific cases that appeared to be 'at odds' with the other participant's perspectives.

The criteria for assessing validity within qualitative research include:

- The impact of the researcher on the setting
- The values of the researcher
- The truth status of the respondent's account

These factors will be explored in the Researcher Reflexivity section.

Silverman puts two other forms of validation forward:

1) Comparing different kinds of data (e.g. quantitative and qualitative) and different methods (e.g. observation and interviews) to see whether they corroborate one another – triangulation.

To some extent this has been achieved through the collection of data on perspectives of support from two different sources – service providers and young

women. In addition the findings of this study have been corroborated through detailed comparisons with the wider literature, which increases its validity.

2) Taking one's findings back to the subjects being studied to verify the findings. This method is known as respondent validation

It was not possible to use this method of validation in this study due to the problems encountered trying to trace the sample for the follow-up interview. It is unlikely that it would have been possible to trace the sample for a second or third time after the analysis had taken place.

A further method to increase reliability and validity in qualitative research would be to arrange for other researchers to analyse the data to see whether they come up with the same themes and explanations as the original researcher. However, one of the problems with this method is that it can be difficult to arrive at a single 'overall' truth. It may be optimistic to assume that another researcher may achieve exactly the same analysis and interpretation as the original researcher who has been enmeshed in the research for the previous years. This then raises the question of which interpretation is the 'truth', and could lead to the researcher compromising their original interpretations and ideas. It could be argued to affect the integrity of the research, in that by employing a researcher from outside of the project to interpret the data, it is ignoring the context-bound and skilful character of the social interaction that has been recorded.

Although as described earlier, regular feedback was received from the supervisors who had read through the raw data transcripts before analysis, but the use of another researcher to analyse the data was deliberately excluded. The researcher was confident that the methods used to obtain the sample, produce the research tools and conduct the research would be sufficient to establish the required level of reliability and validity. The researcher was clear that their absorption in the topic, and knowledge through having conducted and

transcribed the interviews, was required to provide additional insight in the interpretations of the data, that may have been beyond the capabilities of a researcher from 'outside' of the project. The researcher did not want to be a position where conclusions would have to be compromised or 'watered-down'.

5.15 Researcher reflexivity

Positionality is concerned with one's epistemology and recognises the post structural, post modern argument that texts are also partial or incomplete. Instead texts are socially, culturally, historically, racially and sexually located, and can therefore never represent any truth other than those truths that exhibit the same characteristics. It is argued that texts display honesty and authenticity by 'coming clean' about the researcher's own stance and position (Lincoln, 1985).

I am from a white working class background from an inner city area. I am a heterosexual female living in a stable relationship. I come from a stable, supportive, nuclear family, where educational attainment and career progression are valued commodities. Although my family is supportive towards me emotionally and financially, I would not expect to turn to them for support in terms of childcare, or for other types of practical support such as help with household repairs, or accessing benefits and so on. In light of this personal background and experience, I think that my ontological security and associated perceptions of the importance of familiarial independence and inter-dependence were challenged with regard to how much day to day support young mothers were able to access from their own mother I found in this study.

During the course of the research I discovered anew how important social support networks were to me as I had become a new mother. Although I had a partner who lived with me and supported me, my wider support network was much more limited as both our families did not live near to us. Following the birth of our child I developed post natal depression, which left me feeling anxious and lacking in confidence about my new role. During this time I sought help from my

GP who was extremely supportive, and yet I am clear that what was an important factor in my recovery was to attend a number of new mums groups based within the community.

These groups provided me with the opportunity to meet new people in similar circumstances and to develop new and supportive friendships. This experience changed my perception of what motherhood would be like, how much it would change my life and the support I would need to adjust. Had I known this from the outset of the research I may have been able to explore some of these issues in more depth with the participants, it may also have made me think about the concept of social support. As the study progressed I became increasingly able to identify with and understand the pressures and support needs of mothers. My fuller understanding of some of the issues promoted in myself an almost empathetic alliance with my participants – something that impacted in a positive way with the relationships I developed with them in hearing and telling of their stories. I was able to identify with the participants through my experience of motherhood, which sometimes mirrored their own, but often didn't.

Having previously studied Public Health I may have a preconceived idea about what teenage mums would be like in relation to what they should be given by services rather than what they might need themselves. I may have assumed young mothers were less educated, in less stable relationships, and have less disposable income with limited support systems. I also believe that studying Public Health may have affected the language that I've used, or how I've interpretated what the young mothers have said.

From studying for a Master's in Public Health, research methods generally tended to focus on a positivist perspective, however, through this study I came to the understanding that capturing people's experiences using quantitative approaches doesn't fit. As the research developed and unfolded the assumption that high quality research needed to take a positivist perspective was challenged. Upon reflection the research question changed, for example the term 'efficacy'

was replaced from the original study objectives as this term has a legacy of positivist way of thinking about research.

Reflexivity is concerned with the awareness of the researcher's contribution to the construction of meanings throughout the research process. Reflexivity is about acknowledging that it is impossible for a researcher to remain completely 'outside of' the subject matter while conducting research (Nightingale and Cromby, 1999). For this reason it is important to explore the ways in which I, as a researcher, may have influenced and informed the research process. This is particularly important in qualitative data collection, as it is often criticised for lacking objectivity. This involves reflecting upon the ways in which personal values, experiences, interests, beliefs, political commitment, wider aims in life and social identities have shaped the research (Willig, 2001).

It was important for me to reflect on the participants' responses, and how this fitted into the prevailing discourses or public accounts of teenage pregnancy, and how 'who I am' has influenced the accounts the interviewees gave. Would the participants have felt obliged to reproduce the dominant constructions of teenage parenthood? Did the young women feel compelled to describe the services in a favourable light, as they thought that I was somehow connected with the, as a health professional, and therefore provided what I wanted to hear? For this reason I had to make it explicit that I did not 'know' the service providers, and that everything was very much in confidence, and whatever they said would not affect the future care they would receive.

I am a non-clinical professional working within Public Health within a Primary Care Trust within the NHS. I have been working within Public Health for the previous 10 years. I have some, although quite limited, research experience, but only from under-graduate and post-graduate degree dissertations.

As a Public Health professional I had some knowledge of sexual health services locally, but no specific knowledge relating to Teenage Pregnancy Services, so all the contacts I needed to make to help me access the initial sample of young mothers were entirely new to me. I have no doubt that working for the NHS greatly helped me to negotiate the many barriers to accessing my sample. This included negotiating the clinical governance committee within the maternity unit at the hospital in order to gain permission to undertake the study, after having previously gained ethical approval from LREC and the University of Salford. There was a sense of having to 'sell' the benefits of the project to the clinical staff, who felt the teenage mothers were an over-researched group, who needed protecting from unnecessary research projects. I am sure that my employment within the Primary Care Trust helped the project to seem more acceptable to the clinical staff.

In addition to this, when it was necessary for me to recruit additional participants to the study, due to the number of untraceable participants in the original sample, my already established working relationship with the Health Visiting team within the PCT, made them appear much more willing to help recruit participants to the study on my behalf.

As a relatively young female (I was aged 27 when I began the field work), I feel I was able to develop considerable rapport with most of the participants, which I hope helped them to feel comfortable when talking to me, and able to 'open up'. However, I am aware that first and foremost I would have come across to the young women as either a health or academic professional, which may have created a barrier. I was an adult stranger, whom they may have considered to be from a different social class than themselves, and in some,cases, of a different ethnicity to them. The young women may have felt the need to present a 'public' rather than 'private' account of their experiences, as they may have felt that they would be judged by me. From the data I was able to collect, I do not feel that this was necessarily the case as it demonstrates an openness and honesty about

their circumstances. The fact that they did discuss quite sensitive topics with me, and the fact that they were often 'not backwards in coming forwards' to describe some of their negative experiences of services indicated their desire was to be as truthful and open as possible.

During the course of the research I became pregnant myself, and was therefore conducting many of the interviews whilst visibly pregnant. I have no doubt that this circumstance helped to create a greater rapport between myself and the participants, as it gave us an opportunity to discuss our pregnancies and gave us a common interest, which may have added to the richness of the information I was able to collate from the young women.

Experiencing pregnancy and childbirth myself during the research process really helped me to understand the experiences that the young women described to me. It gave me a real understanding of just how difficult and tiring it is to be a mother. I was able to empathise with the difficult circumstances in which they had to raise their children in a way that I don't think would have been possible before I had become a parent.

I also want to describe some other more subjective questions: what was it like interviewing the young mums, and how did I view them? Firstly, most of the time it was an enjoyable experience and fun spending the short time that I did with them. Mostly they were warm and good-humoured and it was easy to build a rapport. They were honest and forthright. However, it was sometimes more difficult to encourage them to open-up and give fullest explanations as possible. I think some of them felt shy, or were not able to articulate their experiences, or perhaps had not really considered some of the issues I was questioning them about in much depth before, and so did not have strong opinions. Sometimes it was much more difficult emotionally when the young women relayed some of the more harrowing experiences to me, and as an outsider and a researcher, I was not in a position to be able to help them.

With regard to the second question, how did I view them? I am not sure what I expected them to be like before I started the study. I wish I had thought about it and written it down at the beginning. It now seems impossible to cast my mind back to five years ago and to think objectively about my preconceived ideas of teenage mums, having now undertaken this journey. How do I view them now? The first word that springs to mind is 'courageous', they seemed to have an impressive ability to bounce-back from the difficult experiences they have faced, and the ability to see positive aspects in what has happened to them and how it has changed their lives.

Chapter summary

In summary, a qualitative approach was taken through out the study as it provides an in-depth insight into young mother's perspectives and experiences. The study is concerned with developing theory taking an interpretivist approach because it is exploring a topic about which there is currently little known, and is aiming to gain an in depth understanding of why something is happening, i.e. why young mothers may become socially excluded and how this may be addressed. The study is ultimately taking a qualitative interpretivist approach as it is about understanding social reality by studying people's attitudes and experiences. The personal circumstances and opinions of the researcher are explored and analysed to identify if, and how, this may influence the conclusions drawn.

Chapter 6 – Findings phase 1: A city-wide support network of service provision

This chapter presents the results of the first stage of the data collection. Appendix 4 summarises the profiles of organisations providing specialised support to young mothers in the city.

6.1 Service Delivery

Most of the services in the city are delivered in a traditional one-to-one setting.. However during the time that the interviews with service providers took place, Sure Start Plus did set up a support group. There was a regular flow of around 8-10 young people attending. The group met once a week, for about 5 hours, during which time a range of activities take place. Activities are identified by the young people and could include improving confidence and self-esteem, parenting skills, cook and eat sessions, or make-up and massage etc. This group did seem to function in a way that allowed young people to develop friendships with one another.

"There is a small % of change in the women that attend, so the members don't form cliques, also the activities available allow the women to mix well." (Sure Start Plus)

"We have found that women have attended the group and met other women from outside their area and met up outside the group. We find this helps the women's confidence when they have someone they can relate to outside the group." (Sure Start Plus)

6.2 The nature of social support

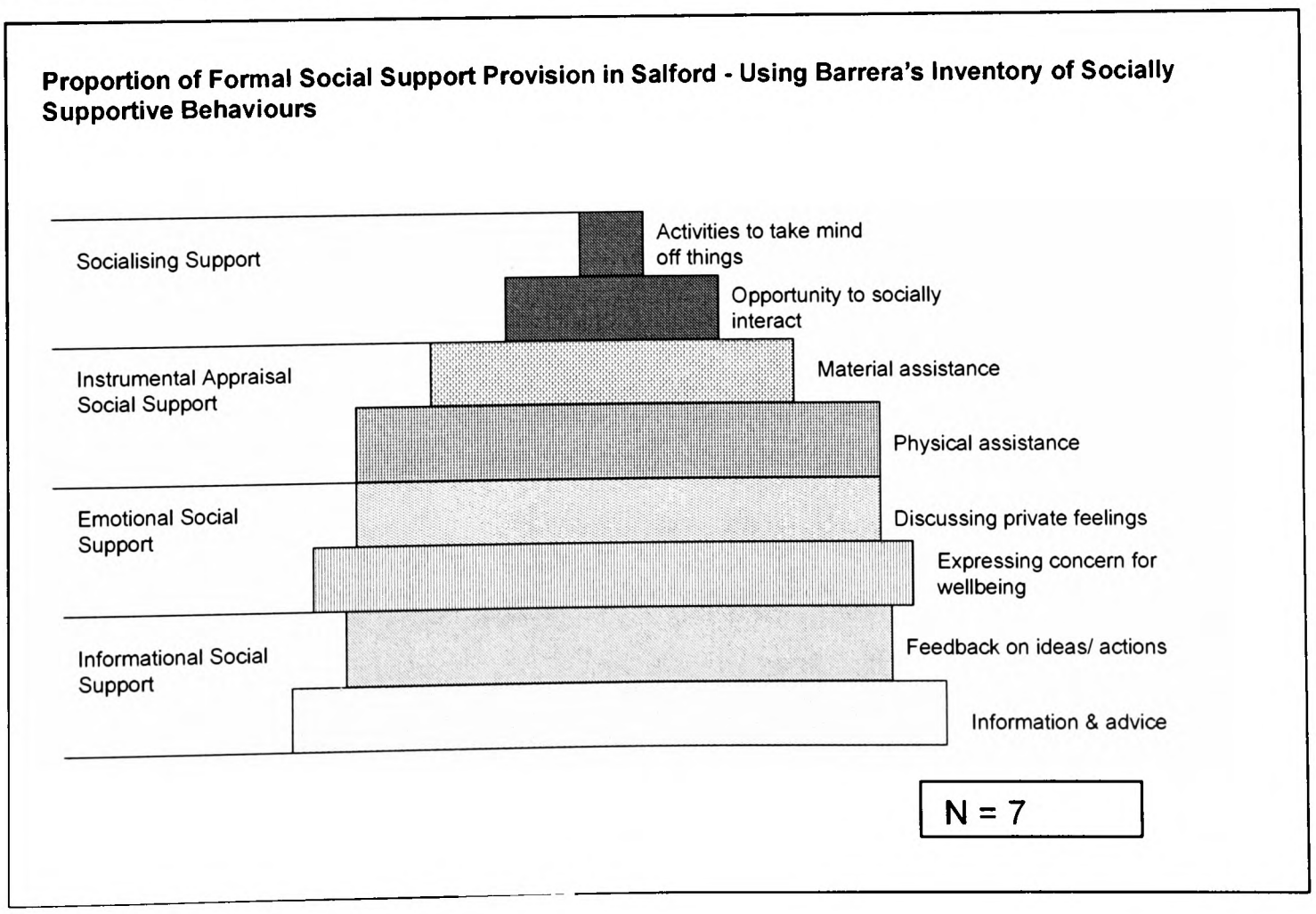
By analysing data derived from questions relating to the nature of social support provided by organisations within the framework of Barrera's model of social support, it is possible to map the provision of different socially supportive

behaviours diagrammatically (Figure 3). Again it can be seen that whereas informational and emotional support are commonly provided by most of the services less is provided in terms of material assistance, and very little support is provided to develop social networks amongst peers through social activities.

The principal section of the Phase 1 findings is concerned with using Barrera's model of social support as a tool for analysing the data collected from the interviews to explore the nature of the socially supportive behaviours provided by services.

Figure 2 illustrates the proportion of the different types of social support offered by organisations supporting teenage mothers in the city, as defined by Barrerra's inventory. In general it shows that informational and emotional social support are most likely to be provided by these organisations and socialising support is the least common form of support provided. More detail of the type of support given was provided by the interviewees.

Figure 2 Proportions of Formal Social Support Provision



6.3 Informational appraisal support

Most frequently, service providers felt they were able to offer information or advice to support teenage mothers about general social problems and relationship advice. The next most common type of informational support provided by services was concerned with emotional and health problems. The 'Other' topic included advice and information around income maximisation. Service providers can fall into one or more categories.

There were mixed answers relating to whether the services provided feedback on young peoples' ideas and actions and whether this was a generally positive experience. This appeared to be related to the differing models that services worked to. For example the project worker from Supported Tenancies and Connexions stated taking a holistic approach to addressing the problems faced by the young people accessing their services:

"The support worker will talk through ideas with the young person and then in follow up sessions will discuss with them the results of the choices that they have made. The focus will be on coaching the young person to find their own solutions to issues. The emphasis is on the young person evaluating what happened and working out for themselves when something didn't go as well as they'd hoped. The support worker would be a facilitator in this process. The emphasis would be on the fact that although something may not have worked as well as they would have liked, they have learnt from the experience and can now try another course of action." (Supported Tenancies)

"This is a huge part of what we do, this service differs from the other personal advisors because the officer's background is not in education but in social care. Also it differs because it is more flexible and able to work much more intensively with the young person" (Connexions)

This type of appraisal support described by the service providers may offer some insight into possible opportunities for developing linking social capital, or a situation whereby service providers and professional workers are able to work alongside young mothers on an equal footing to decipher potential routes to future inclusion.

6.4 Emotional social support

To some services such as Sure Start Plus & Brook, expressing concern and allowing the young person to disclose their private feelings and talk about any concerns and worries in their private life in confidence was key to the service provision. However, even for services where the main aim of the service was not this, but for example more concerned with education or training, service providers stated taking a holistic approach. This meant that fundamental personal problems would be addressed and tackled initially in order that the service providers could then move on to address other needs such as training or employment, particularly if the personal problem may be acting as a barrier to addressing the need that the service was aiming to provide. This type of social support can be considered to be working towards the SID approach to tackling social exclsuion outlined by Levitas (1999) earlier, whereby services aim to support young mothers through access to education and training as a primary aim, by addressing personal barriers as a means to an end, to work towards social inclusion.

For example, to take a quote from the interviews with the Reintegration Officer and the Supported Tenancies Officer:

"It is important to show interest and concern in the young person's wellbeing. Although our service is about education, we take a holistic approach. We try to address anything that stands in their way of learning". (Reintegration Officer)

"The support worker would establish how the young person was feeling, how they were in general and seek as to whether there was anything that could help them in order to make them feel better. In terms of providing an opportunity to talk in confidence, this would happen to a certain extent, but is not really the main feature of the support plan. Young people may talk about their feelings in relation to family members, their partner or children, and the support worker would provide a listening ear to an extent, but would talk to the young person about other sources of help if these kinds of issues started to go too in depth or beyond the worker's expertise." (Supported Tenancies)

6.5 Instrumental appraisal support

Figure 3 highlights the different types of material and or physical support that services provide.

Figure 3 Instrumental Appraisal Support provided by services

Organisation	Sure Start Plus	Connexions	CAB	Reintegration Officer	Brook	Early Years	Supported Tenancies
Travel expenses	No	Yes	No	Yes	Yes	*	No
Access to equipment	Yes	Yes	No	No	Yes	No	Yes
Other financial support	Yes	No	No	No	No	No	Yes
Childcare	No	Indirectly	No	Yes	No	*	No
Giving lifts	No	Yes	Yes	No	No	No	Yes
Accompanying a young person physically in a stressful situation	Yes	Yes	No	Yes	No	No	Yes
Other	No	No	No	No	No	No	Yes

** Teenage Parents who wish to train to become childminders or work in nurseries can access training and childcare for free.*

The levels of material assistance provided by services differed significantly. For example Sure Start Plus were able to loan out equipment such as Reality Dolls, clothes and safety equipment, but were unable to provide support with travel

expenses, whereas Brook and Connexions were able to provide travel costs in some cases. In addition Brook could provide access to free contraception and Connexions access to I.T. equipment. Supported Tenancies loan temporary cookers, heaters and airbeds, and will also pay for furniture removal when the young person first moves in to their property. This type of physical support can be considered to be more in line with the material deprivation approach towards tackling social exlcusion decsribed by Levitas, as it is concerned with providing the bare minimum level of equipment required for successful parenting. Though it is unlikely to have any significant implications for the future social inclusion of young mothers as what is being provided is obviously quite limited.

Similarly access to physical assistance varied. Access to childcare was provided through the Reintegration Officer, Early Years and more indirectly through Connexions. Sure Start Plus, Reintegration Officer, CAB and Connexions were all able to accompany a young person to a meeting in a stressful situation, such as a case conference, benefit or housing appeal or liaising with the school. Again these findings highlight that the types of support being provided by services is varied, but that no one individual organisation provides all types of support, and therefore signposting between services is essential.

6.6 Socialising support

Socialising support refers to support to facilitate young mothers socialising among themselves such as social interactions, fun and relaxation, talking about interests, and providing activities. There were very few opportunities available for young parents to socially interact with one another to build support networks. However, Sure Start Plus had recently set up one group at the time the interviews took place, this was the only group in the city. It seems a missed opportunity, to foster the development of social support amongst peers as young people are accessing a particular service anyway.

Perhaps services could be working towards developing opportunities for young people sharing similar circumstances to support one another through peer

support groups or buddying-type schemes, which may be a more acceptable type of support for young people and have a more sustainable impact.

6.7 Discussion: A city-wide support network of service provision

This research has highlighted the benefits that can be attributed to tackling an issue at a multi-agency level. The development of a specialist team to support young mothers has led to the creation of a centralised referral system with effective and consistent referral and signposting between services provided by a broad range of different agencies, each with different remits and priorities to support the needs of this particular socially excluded group. This model of working has obvious benefits for service users. All services were familiar with the others that existed and keen to refer on if an issue was raised that was outside of their expertise. This networking between service providers could be seen as a 'support network of service providers'. The types of social support being provided by services is varied in its nature and delivery, but no single organisation provides all the types of support. Therefore effective signposting between organisations is essential. What is clear though is that there is some overlap in the provision of some types of support.

Many of the services are keen to support young people in relation to any personal problems they have. Many services (including those with a single specific remit such as sorting out housing, for example) have adopted a holistic approach by focussing on the individual rather than dealing with each of their problems in isolation. This type of holistic approach is more likely to facilitate the pathway to social inclusion as it seems to overlap the Levita's (1999) explanations of social exlcusion, rather than purely focusing on a rigid SID approach at any cost, as may have been expected.

However, it perhaps may be more appropriate to see a move away from traditional one-to-one service delivery that the public sector traditionally specialised in. Again, encouraging the development of groups, and more flexible

services, such as drop-ins, at accessible times, based within communities may be a positive way forward, and more conducive to developing social support networks, and at some level, work towards developing bridging social capital.

There were mixed answers relating to whether the services provided feedback on young peoples' ideas and actions and whether this was a generally positive experience. This appeared to be related to the differing models that services worked to. Due to the nature of the service being delivered traditional methods of service delivery and their settings it may be more difficult for some services to move towards a more social or holistic model working with teenage mothers, rather than 'treating' them.

However, what is less clear is how this 'support network of services' is enabling social support to be developed amongst the young people accessing the services, particularly at the community level. There are not many opportunities currently to encourage the development of social support networks amongst young mothers and mothers to be in the city. It would be useful to see groups forming out of the young parents' own communities so as to add to the sense of growing community capacity and social capital.

Summary

This chapter has presented an overview of the range of services that provide specialised support for young mothers across the city. The exact nature of the support being provided through formal services based around the four key area of support outlined in Barrera's Inventory of Socially Supportive Behaviours has been explored. By using this model of social support it has been possible to identify that although much support is available to young mothers in terms of emotional and informational support, there are gaps in the provision of socialising support and opportunities missed for creating peer support networks amongst groups of young mothers experiencing similar difficulties. Despite this, there is a

clear and holistic 'social support network of services' within in the city, which could go some way to buffering against the effects of social exclusion.

Chapter 7– Findings phase 2: The nature, role and function of formal and informal networks

Chapter 7 presents analysis and interpretation of phase 2 of the empirical work; the interviews with the pregnant young women/young mothers. This work will then be drawn together with the findings from the phase 1 empirical study in the final chapter.

7.1 Overview of participants

During the antenatal interviews a total of 18 young women were included in the study. The participants ranged from age 15 to 18, the mean age being 16.7 years. The participants were at various stages of their pregnancy ranging from those early on (only 11 weeks in one case) to women who were much nearer the end of their pregnancy, at 30-40 weeks. None of the women included in the study had any other children.

Half (n=9) of the respondents included in the study lived at home with their families, a quarter lived with their partners and a quarter lived by themselves. Over half of the participants lived in council property; over three quarters lived in rented accommodation of some form. Of those who lived in privately owned property, they lived with parents who owned their own home.

Sixteen of the participants identified their ethnicity as being White British. One of the women was Indian; one was White and Black Caribbean. Many of the respondents had been in education or employment but felt that they had had to give this up due to being pregnant, for physical reasons in the case of the women who were nearing the end of their pregnancy. Five of the participants should legally have still been attending school, but only 2 were attending.

Just under half of the participants interviewed attended for the antenatal appointment and consequently the interview by themselves. Eleven participants

attended with another person. Participants who did bring someone with them for support were most likely to bring their mother, or partner.

Due to the problems encountered in following up the participants for their postnatal interview, described earlier in the section, the postnatal sample differed significantly from the original sample.

The participants ranged from aged 16 to 19, the mean age being 17.7 years. The age of the participants' babies ranged from 2-18 months, with half the interviews taking place before the baby was three months old. Four of the respondents included in the study lived at home with their families, a further four lived by themselves, and the remaining 2 lived with their partners. Seven of the participants lived in council property, and the remaining 3 lived in privately rented accommodation. Nine of the participants identified their ethnicity as being White British, and one participant was White and Black Caribbean.

Table 7 summarises the main sources of formal and informal support identified by the participants, or their social networks, as well as the main gaps that they identified. All sources of support/ gaps were identified by the participants, and have been displayed in no particular order.

Table 7 – Overview of sources of support and gaps

Participant	Informal Sources of Support Identified	Formal Sources of Support Identified	Gaps in Support Identified
Participant 1		TP advisor Social worker	Financial Family Mum Partner Friends
Participant 2	Partner Family Friends	Sure Start TP advisor	Housing Employment Midwifery advice
Participant 3	Friends Family Partner	TP advisor	Childcare to return to college
Participant 4	Friends Family	TP advisor	Partner
Participant 5	Partner	TP advisor	Friends Family
Participant 6	Mum Other mums on estate Partner's family	TP advisor TP group	Friends Partner
Participant 7	Sister Partner Friends Mum		Childcare to return to college
Participant 8	Mum Family Older brother Partner	Midwife	TP team Friends
Participant 9	Partner Grandmother Grandmother's friend Partner's family	Housing Teenage father's group (supporting partner)	Friends Childcare to return to college TP Team
Participant 10	Partner Friends Family		Midwifery support TP Team
Participant 11	Partner Family Friends	TP advisor	
Participant 12	Parents	Antenatal care TP Advisor	Housing Partner Friends
Participant 13	Parents Partner Sisters Aunty Friends	School TP Advisor TP group	
Participant 14	Mum	TP advisor	Housing

	Sisters Friends Neighbour	Midwife General practitioner TP group	
Participant 15	Parents Friends	TP advisor	Partner
Participant 16	Mum Partner's mum Mum's friend Grandparents Friends	TP advisor TP group	
Participant 17	Foster parents Friends Partner Partner's mum		Parents
Participant 18	Friends Parents Partner	TP advisor	
Participant 19	Parents Partner's mum Partner's sisters	TP advisor Spurgeons (Family support project only available in one area of Salford)	Partner Friends
Participant 20	Mum Partner's sister Neighbour Partner	TP advisor	Friends Childcare to return to work fulltime
Participant 21	Parents Aunty Friends		Partner
Participant 22	Partner's parents	Spurgeons (see above) Health visitor Midwife	Partner Family Friends
Participant 23	Parents	Breastfeeding group Health visitor	Partner Friends Childcare to go back to work
Participant 24	Mum's friends Step-father	General practitioner Health visitor Social worker	Mum Partner

Most participants used 1 or 2 formal services as part of their support network. The majority of participants (n=14) identified the TP team as a source of support, whilst 5 participants attended a group run by the TP team, and 1 attended a breastfeeding support group. Other sources of formal support identified included the school, the midwife, GP, Social services, Housing, the Health Visitor and

Spurgeon's charity parenting support project was also mentioned by 2 participants.

Most participants appeared to have around 3 or 4 different sources of informal support within their networks. Eighteen identified their mum, family or parents within their support network; six identified their partner's family. Other sources of informal support included friends, aunties, grandparents, step-parents, foster parents, neighbours, parents and grandparents' friends, and siblings.

In terms of gaps young mother's identified within their social network, partners were most commonly identified (n=10), followed by friends (n=9); parents or family were only identified in 3 cases. Five participants identified a gap in childcare support that was preventing them from returning to college or work.

7.2 The Nature, role and function of formal social support

It is useful to return to social capital theory briefly to examine the extent to which formal services may provide the type of socially supportive behaviour that may constitute bridging social capital. The definitions below are a reminder of the different types of social capital, and how bridging and bonding social capital differ, as these concepts are discussed in relation to the findings throughout the chapter.

Bonding Social Capital Definition: Bonding social capital is concerned with networks between groups who see themselves as being the same as one another.

Bridging and Linking Social Capital Definition: Bridging social capital is concerned with relationships between people who are not necessarily alike. Linking social capital is concerned with networks of trust and respect across formal or institutional power gradients. Included here would be formal community networks such as local service providers.

Participants were asked to talk about how much they got 'out and about' to attend activities in their communities and to visit their friends and family etc. Half (n=9) of the participants stated that they got 'out and about' almost every day, or a few times a week, and did not feel isolated. The remaining half of the women got 'out and about' once a week or less, and commented on feeling lonely or bored. These feelings appeared to be further exacerbated by the lack of supportive friendships experienced by some of the participants.

Half the participants commented upon having a wider social network and attended various activities, which may be considered to be socialising support. These responses were very varied, with some women getting out and about with friends, family, hobbies, or occupations everyday, whilst others remain relatively isolated, and only get out to see their family, for example, once a week. Money was mentioned as a factor that contributed to the young women's sense of isolation.

Participants were asked to talk about their views and experiences of attending local groups for mothers and babies and young parents to be. Approximately less than a quarter had attended groups, but those that did found it was a positive experience and an opportunity to meet other mums, share experiences and learn new skills.

> *"You get loads more from groups, you get loads from them. I'm going to the cooking one and the pelvic floor one. See for me, you have to be there at 10:00am in the morning so I need to arrange a lift. They said something about a taxi, it's impossible to get the bus from here and no one I know drives, so. All I do is sit looking at these four walls everyday, so I want to get involved with groups as much as possible." (Participant 6)*

"It gets me out of the house for a good 6 hours on a Thursday. They do the talks in the morning, in the afternoon you can do cooking or arts. In the morning we discuss what we want to do in the afternoon. Some women want to go out and do whatever, others want to stay and do cooking. So it's up to you. So I usually stay and do the cooking because I'm not very good and need to learn." (Comment re: Young Mum's Support Group) (Participant 14)

"Yes, Salford Women's Centre, I've been going there for the last four weeks. There's women my age there, mums to be and women that have had their kids, so you can ask them what its really like. They're aged about 16-23. I enjoy talking to adults even though I'm 16, I'd rather have an adult tell me something than another kid." (Comment re: Young Mum's Support Group) (Participant 4)

For those who attend the support group regularly, it obviously means a great deal to them in terms of helping to fill their week with activities other than those concerned with the pregnancy, and to give them the opportunity to develop social support networks. Yet, as found in the first phase of the study, very few services were working to develop peer support networks, possibly a missed opportunity for bringing and linking social capital.

At the antenatal stage many participants, almost three quarters, expressed a reluctance to attend groups, some felt too shy to go on their own, or did not like being in group settings, others were concerned they might be expected to talk about their personal experiences of emotions and felt uncomfortable about that.

"It depends what questions they ask you, because sometimes I just sit there and think I don't like explaining my feelings to other people when there's loads of people there." (*Participant 8*)

"My midwife and care worker were telling me things, but I prefer to be in my flat, on my own. I prefer to do my own thing." (Participant 8)

"Yes, I went to a teenage mothers group at the Women's Centre. Well, I didn't really like it because it was all women that had already had their babies. I didn't really like the idea of being in a group." (Participant 17)

"Probably the Women's Centre really as they have more groups and stuff. I think it run by the TP Team because she was the one that phoned me and let me know it was on, because its all people my age, its not all 30 odd year olds. They don't look at you as if to say 'god, I've got a husband, or you're my daughter's age'. (Participant 6)

"I'm in a load of support groups at the moment. Homestart in Little Hulton, I've got Swinton Families, there's a new centre just getting built on Beechfield (Children's Centre), well when that opens I'm going to start going there. It's good to have someone to talk to. I go out everyday. I just go out with my mates, or if we don't go out she just comes round here because I can't really go out on my own, I just don't like it, I can't go to town, I can't go anywhere on my own. When I go to the groups they have to pick me up." (Participant 24)

Attending the groups appeared to be giving the women the opportunity to mix with other mothers, who they may not have met otherwise, in a non threatening or stigmatising environment. It gave them the opportunity to make friends with other mothers, and gave them somewhere else to go during the day, to get out of the house, and to reduce feelings of isolation.

Participant 24 felt unable to go out on her own, as she felt too unconfident and anxious when on her own. In terms of young mothers developing their own socialising support networks with their peers through attending groups, there was little opportunity or desire on many of the participants' parts to do this. Perhaps this finding in itself is a reflection of the level of social exclusion already felt by the young women, whereby they have felt that they wouldn't 'fit in' with the group, or would be stigmatised. Of the women who were not involved in the formal group, many had very little opportunity to mix with friends or other young people, and admitted to feeling isolated, but still lacked the desire to attend a group organised by a formal service provider. This type of support has got potential to facilitate social inclusion through the provision of a bridging and linking type social capital, and through supporting women to learn new skills, supporting positive parenting, and through widening women's social networks, and yet it is not being taken advantage of to its full potential in its current form, or does not meet participants' needs in some way.

7.3 Holistic versus medicalised

The women described how helpful or supportive they perceived different services to be. A key theme drawn from responses was that services were seen as supportive by mothers in their ability to provide reassurance in relation to their baby's health. Provision of the opportunity to discuss any worries and for these concerns to be dealt with in a holistic way was also considered supportive. The young women valued having a professional who would reassure, provide positive feedback on how they were getting on, and above all have time to have a 'chat' with them.

> *" The doctor I had was brilliant, he spent time with you, he didn't care how long he was spending with you. There was a lot waiting and he used to make sure that he did it thoroughly all of the time. He was dead nice." (Participant 2)*

"I saw the stop smoking midwife before I had her and I stopped. I went to see her and she rang me up every couple of weeks to see how I was doing. But it was nice because it wasn't just how you doing, how many have you had, she was also how are things going how is baby, because I knew that she was a midwife as well. It was nice because I'd just come home with her and she was not too well, so I could chat to her about that as well." (Participant 23)

"I always worry about his health, I don't know why it's just like, what if, what if? I don't worry about mine, just his. I took him to the doctors because he had a rash, and he said it was just because of his dribble. I said I'm sorry I feel stupid, and he said, no don't worry, you come when you want, and reassured me that I can go whenever I feel worried." (Participant 9)

Additionally, health professionals were valued by the young mothers, and positive feedback and reassurance from professionals was seen as important in terms of self-esteem and contributed to feelings of being a 'good' mother. The manner in which health professionals communicated information was also valued. The ability to communicate without instilling feelings of belittlement or stigmatisation was considered important.

> *********** (Member of the TP Team) was really good. Its how she comes across, she's got the right body language and the right attitude, she's really nice, really nice, she's not pushy or anything. They know how to speak to you." (Participant 15)*

> *"The TP Team are the most helpful, just because they are more involved, more involved than my own midwife. She's not like a midwife, its just like talking to your own mum or something" (Participant 11)*

"I saw the Health Visitor in the first few weeks, but then she said I was getting on fine and she didn't need to come round any more, but she was good when she was coming round. She made sure I was doing everything right and explained to me what I could do instead of doing something else, she was really good. Everyone had the same attitude towards me if you know what I mean, a really good attitude, like, how you doing, you seem to be doing really well, making me feel better you know." (Participant 9)

These responses reveal that reassurance is extremely important to the young women, this in turn may help to build confidence, and self fulfilment in parenting. Thus to some extent formal services can be considered to be providing certain aspects of bridging social capital, that may in turn facilitate social inclusion through their role in supporting positive parenting.

However, in around a third of cases, young mums described situations where they had felt excluded from the care they were receiving, or that they had not had an adequate opportunity to discuss all their concerns, or that there was a lack of information provided. A theme emerged around circumstances which were perceived as being unsupportive, which appeared to occur where mothers felt excluded from the care. How useful the information was perceived to be may also be dependent upon the quality of the relationship between the staff and the patient, and whether the young women felt they could trust the professional and the information they were being given. The following extract highlights this point:

"Its alright, but I think they could do better, they could be more open about things, because since I've been coming here, all they are concerned about is the baby and not me. This is why I was in on Sunday, the baby didn't move." (Comment re: antenatal checks at hospital) (Participant 12)

*(Mum takes over) "I think it's an explanation of what a pregnant woman goes through, nobody's actually sat down and said, this happens, that happens. She understands that, but why does it happen. I think she needs to feel a little bit included more. Its alright them saying baby's fine, baby's fine, what about her within herself. It's a matter of just explaining to her what different pains are related to and why it can happen. Instead of just everybody saying your fine, you're fine, you're fine. If she doesn't feel well, she wants to know why. Dr ***** is fantastic, its just the nursing staff. They'll tell her something, then it's like Mam, Mam, and then I've got to sit and try and explain to her. We've had problems in the past with his registrar and another doctor and he knows the circumstances and if anybody winds her up, they wind me up. You know, one woman when she lost her baby last year, said go home and take a laxative, and when you think you've lost it come back. Well I had her pinned up, I weren't amused, and she was only 16 at the time. I demanded another doctor and Dr ***** has took over since then." (Participant 12's Mother)*

(Young mum again) "I'm always in here (hospital) and they've not really told me anything, and it's really, really bugging me, because I know that something's wrong inside me (starts to cry). Sometimes because of the pains I'm getting inside me, it feels like I don't want the baby inside me no more. Because it's getting to the point where they're not telling me, and I'm getting all these pains, its worrying me to death and stressing me out. I suffer with anxiety and depression and mental health and it's all getting on top of me. People like me, only 17, women, don't even know what pregnancy means half the time, and they come in here and they're not being told what they need to be told." (Comment re: antenatal care in hospital) (Participant 12)

This is only one example, but this kind of formal support is unlikely to bring about any positive reinforcement, or to build confidence in the parenting role, and so may limit social capital production. There was an overwhelming sense from the participants that they found pregnancy a stressful and worrying time, and formal services were in a prime position to support them through that time.

7.4 Informational support

Most respondents did not find the information they had received through antenatal or parenting classes particularly helpful, and participants felt that their information needs were not being met by some services. Only 2 participants attended for formal antenatal/ parenting classes provided at the hospital. Particularly interesting in light of the previous findings where participants described the informational support they had received from their own mothers about childbirth, and how valuable that appeared to be to them.

> *"No I got no information about parenting, that would have been really helpful, because I was only 17. It would have prepared me more, I got offered nothing. I got no extra help even though I was younger." (Participant 22)*

> *"I didn't really want to go to the antenatal classes, but the midwife come here and I did it at home instead and she gave me the information anyway." (Participant 16)*

> *"No, we need something about that (parenting) because obviously we don't know nothing." (Participant 18)*

There was a low uptake of the classes, although some respondents stated that they had not been offered such classes in the first place and would have liked to attend. What is apparent is that a number of young mums were put off attending the classes because they felt that it was for couples only, and felt that they would

be stigmatised due to the fact they were not in a stable relationship, and would be younger than the other mums attending the group. The suitability of the service provision appeared to be particularly important.

> *"I didn't go to antenatal classes because it's partners as well, it put me off going as I didn't want to go on my own. If they had one that you could just go to on your own then I would have gone." (Participant 6)*

> *"I didn't want to go on my own to the antenatal classes. I didn't really want to go to a group of people that I don't know, on my own. I would if someone could have come with me. "I mostly got that (information about parenting) from my mum." (Participant 20)*

Young mums were receiving a broad range of informational support from the formal services they came into contact with, though this was not perceived as being particularly helpful or relevant to them. Evidence suggests that merely providing information for people in order to encourage them to make what are effectively lifestyle changes, such as stopping smoking, taking up breastfeeding for example, may be insufficient in actually changing behaviour. Instead what is required is education or skills development in the practicalities of how to make the change or take up the new behaviour, as well as ongoing support (Whitehead and Tones, 1991). What is clear is that more practical support, such as instrumental support, or emotional support, when what is being provided from one's informal networks is not quite enough, is more highly valued by young mothers. Informational support has been found to be the most commonly provided type of support that formal services provide for young mothers, and yet this study has found that it is not perceived as particularly valuable and seems to have limited impact.

This appears to be a missed opportunity for services to provide the very kind of support that could constitute bridging social capital and perhaps facilitate social

inclusion through the development of new skills and a greater sense of self-fulfilment amongst young mothers. Many of the young women were reluctant to access this informational support for fear of being stigmatised, or felt unconfident communicating with professionals, and so were missing out on this important learning opportunity that is available to every other new mother. According to the views expressed by many of the respondents interviewed, it would appear that services are not being delivered in a way that is accessible or acceptable to young mothers.

7.5 Instrumental, practical and material support

In the first phase of the study instrumental and material type support was one of the least provided types of support that services were delivering. The main topics of instrumental support identified by the participants that were delivered by formal services tended to be around issues such as housing and maintenance, rent, benefits, grants, and help with completing forms. This tended to be provided by formal services such as the TP Team, Social Services, or the CAB, or from informal sources such as from the participant's family as described earlier.

Again, what seems to be of importance to the young women is having someone who they feel they can talk openly to, who takes a holistic approach which considers the wider aspects of their life, rather than just concentrating on a single issue, and who treats them in a non-stigmatising way. Participants seemed to value highly this instrumental support, where there was a sense that any problems that they were having could be handed over to someone else to sort out for them (similar to child-parent relationship, as commented by one respondent), which could be seen as being indicative of a lack of self-efficacy and independence. In particular the support provided by the TP Team was valued as it was perceived as being very broad in the topics it covered, and almost holistic in its approach. This reflects the findings from the Phase 1 study relating to formal social support provision.

The support received from the TP team was most often described in terms of instrumental supportive behaviours such as physically being there with someone during times of stress, helping with practical tasks like changing nappies, making bottles and teaching new skills. However the perceptions of this support could be considered along a continuum, from those finding the service to be extremely helpful and supportive, to those who felt they would have liked more input and support, to those finding the support to be intrusive. Perhaps those that found the help intrusive, were those that were actually in greater need of the support and struggling with parenting, but felt the services were being critical of them, and may even lead to questions about their suitability as a parent.

The following are some examples of the comments that were made about different types of instrumental support that participants perceived to be helpful. These responses highlight that one of the key, and most valuable functions of formal services appear to be around supporting young mothers basic material needs, including addressing housing requirements, maximising their income, and providing basic equipment. Clearly these functions are essential factors in the route to social inclusion.

> *"She's been brilliant, she's sorted out my income support, because they weren't going to pay me, now she's been on the phone to them they are going to pay me and back dating the money that's owed." (Comment re: CAB) (Participant 10)*

> *"They've helped me with everything, everything. Job seekers, rent with my house. (Mother) They told when to come off JSA for income support to get the baby's grant and everything, they've been quite good." (Comment re: Connexions) (Participant 12 and her mother)*

"When we was getting the house they had this man that would help us out and sorted out our house and cleaned it all up for us, what we wanted to do." (Comment re: New Prospect Housing) (Participant 7)

The following two participants commented on the equipment they had received to help them care for their babies.

"Sure Start was probably the most helpful service because of all the equipment they've given me." (Participant 6)

"Sure Start bought me a Moses basket and baby monitors and a safety gate, and a changing bag, and a little play gym." (Participant 6)

Similarly the following extracts demonstrate the role of services in helping a young mother to learn practical new skills associated with effective parenting in a way that was accessible to her. These instrumental, and practical functions of formal social support appear to be fundamental aspects to supporting young mothers to become socially included.

"The TP Team have been the most helpful, because I never used to do nothing for (baby's name), nothing. And they said you've got to start doing bottles, so I'd do bottles more, they used to pester me, and then I'd start doing nappies, and come round and see how I was getting on. At the moment, I've started playing with her more, at this group I go to with (worker from Sure Start) they do sticking and gluing, so I've started getting her stuff like that now." (Participant 19)

"Sure Start yes, I've had packs off them and I know where the office is. They came out and shown me baby massage and give me a play mat that the baby goes on." (Participant 2)

7.6 The continuum of instrumental support

During the antenatal interviews young mums' experiences of accessing support with social housing were more problematic. The quotations below are illustrative not just of a lack of social capital, but a lack of economic capital and material and practical constraints to coping with motherhood. Problems encountered included long waits for accommodation and a lack of feedback as to what was happening whilst on waiting lists, poor quality accommodation, and not being able to get accommodation near to their family, thus reducing their support networks, and constraining self-efficacy and independence.

> *"I was living in university accommodation but because I'm going to be a mother and things I can stay there until I've had the baby. But the thing is, because my family found out at the last minute, I had to get out of there so I've moved into a hostel. But before I applied, I went to Housing and I told them the situation that after the baby, I've got nowhere to go basically. So that's the only way, the housing process is going through." (Comment re: New Prospect Housing) (Participant 1)*

> *"Not very helpful, it's alright in some ways. It's took them four months to contact me, I thought they'd just forgot about me. They should have just contacted me in between to say they're still looking and updated me. They've found me a flat in Eccles, the only problem is my mum lives in Salford so I was a bit thingy. But they said if I move there, in a few months they can get me somewhere in Salford. Its easier in Eccles because there's loads of council places, there's loads of 21-25 year olds in Salford so they don't have many flats going. I'd have preferred not to be moved from my mom, but my sister lives in Patricroft so I've still got my sister near, but would prefer to be by my mum." (Comment re: New Prospect Housing) (Participant 14)*

"I don't even attempt to go in and see them. I'm sick of trying to phone the emergency number. I've got to get one of the Health Visitors to go in and see them because my house is freezing. I'm on the end of a row. I've got no insulation in the walls, I've only got one radiator which is in the front room, and all the heat is going through the walls. And the baby's bedroom is the same, absolutely freezing, and I can't live like that because once the baby comes and my Health Visitor comes she's going to go mad. So I'm going to get her out to see before the baby's born so I can get something done about it." (Comment re: New Prospect Housing) (Participant 12)

A theme emerged around financial/material support and participants' expectations of what should be provided through formal services, particularly around access to appropriate housing. As in many cases services were not in a position to offer this support, so participants' expectations failed to be met. Some participants experienced a lack of instrumental support in terms of accessing housing. It could be argued that perhaps young mothers' perceptions of what they should be entitled to were too high, but there were a few examples where young mums were left, sometimes for months on end, during pregnancy sometimes up until the birth, not knowing where they were going to be living when the baby was born. This is not an uncommon finding, a study by Burghes and Brown (1995) states that mothers commonly found that they were not able to put their names on waiting lists for social housing until they were 18, and even then they would have to wait up to two years. The Teenage Pregnancy Unit found that teenage parents were likely to be housed in poor accommodation on large estates often away from family and friends or other sources of support. Teenage parents were six times more likely as other households to live in areas dominated by local authority housing (Botting et al, 1998). Speak et al (1995) found that for many young mothers, a flat of their own with a young child is an isolating experience, when they are already isolated from their peers by being a parent.

Post partum, housing was not raised as such a contentious issue as in the antenatal interviews, perhaps because during the pregnancy most of the young people had been able to resolve these issues. However, perhaps the high proportion of participants who were untraceable in this study (whereby only four of the original sample of 18 were traceable, after the birth of the child), highlights their unsettled circumstances. Also it is worth commenting on the fact that often young mothers are re-housed in different areas of the city from their parents and social support networks which can have adverse effects on their ability to cope with parenting. All of this evidence is illustrative of the difficult and poor living circumstances that many of the women in the study were experiencing.

Approximately a third of participants experienced a lack of instrumental support in terms of accessing housing. This differed from other forms of instrumental support, such as that provided by Social Services and in one case the TP Team, which was perceived as being too readily available and too intrusive by a further third of participants.

> *"The TP Team were okay to start with but then they started coming round all the time when I'd had him and I felt like they were interfering and in my face all the time. Every time I did something, they'd tell me to do it a different way. In the end I used to go out when I knew they were coming, but my dad went and told them where I was. One day they had come to see my cousin who's got a baby and I was there and he had been bitten by my dog, only a really small bite. And she said that he'd need to have the bite frozen and everything, and he hadn't he'd just needed paper stitches, and she said well that's what the hospital told me. That's what they're like, she'd just got it all wrong and was trying to make out it was loads worse than it was, that's what they're like."* (Participant 21)

"Now everyone knows I'm pregnant they've got to calm down. It's helped everyone in the house. There's a baby on the way, we've got to do this, we've got to put a stop to that. But social workers don't see it that way. They said to me last week that if I don't move out of my mum's by the time the baby's born that they'd take her off me. I've been told to stop getting stressed out because of my blood pressure, but I can't. But at least I've got my flat sorted now." (Comment re: Social Services) (Participant 14)

So it is possible to see that in the case of the instrumental support provided by New Prospect Housing (Social housing provider), it was perceived in many cases as being insufficient and more was required, whereas the support provided by Social Services, although instrumental in some ways, was perceived as being intrusive, and as a contributor to an already stressful situation.

The problems that the young mothers were encountering in accessing suitable housing is likely to have a huge impact upon their ability to parent effectively, and is likely to constitute a key factor in their ongoing social exclusion. In this particular instance formal services can be considered to be failing to provide the appropriate linking capital to facilitate young mothers' social inclusion.

Formal services have an ideal opportunity to provide support that could be considered to constitute bridging and linking social capital by helping to develop networks between people who may not necessarily be alike (living in similar circumstances or experiencing the same pressures), or between service users and providers, where power relationships are not equal. However many services do not appear to be being delivered in a way that young mothers feel comfortable to access, or communicate with, or most importantly, trust. This may possibly be reflecting the levels of social exclusion already felt by many young mothers. This may be limiting the effectiveness of services in acting as a conduit for the production of bridging social capital for young mothers.

Many services were experienced by young mothers as being useful and supportive, in particular the TP team was most often cited. Services were found to be supportive if they provided practical, instrumental and material types of support, were approachable, holistic, and provided tailored one to one support. In addition services can be considered to be providing support by providing an information resource for young women, particularly about benefits and housing, which helps them to manage financially.

Some informational type support provided by services was not perceived as useful or relevant to young mothers in the context of the complexities of their lives. Many young mothers were also reluctant to access services for fear of being stigmatised or criticised.

7.7 Nature, role and function of informal social support networks

This section of the findings presents data relating to the perceptions and experiences of the support young mothers received from their informal social networks.

7.8 Practical and Instrumental Support

Nearly all the women in this study (83.3%) felt they had received more than adequate support from their families since their pregnancy. Much of this support took the form of instrumental support, which was predominantly linked to their mother. Support received from families and more specifically, mothers, was considered the most important source of support. Support from families seemed to be relatively consistent throughout the pre and post partum period. However the young women were able to describe the practical or instrumental support they received from their mothers and wider informal networks in much more detail, after the birth of the child, and seemed to value this support to a greater extent.

"Money, comfort, shoulder to cry on (mum takes over at this point), every time she's in the hospital I'm with her constantly, all her appointments…." *(Participant 12)*

"The support I get is, is that it's there if I need it as much or as little as I want really. Well like the first couple of weeks they (parents) were coming over everyday for an hour or so, mainly so I could have a bath, you know with like lifting things when I first came out of hospital. Now they just bob over for visits, but they'll come over if I've had to go out for stuff on my own." *(Participant 23)*

Participants also described instrumental or practical support they had received from their partners. During the postnatal interviews only two of the participants lived with the baby's father in a traditional nuclear family, three of the participants had no contact at all with the baby's father, the rest (5) had varying degrees of contact (from seeing each other maybe once a week, to seeing each other much less frequently, as for example two partners were serving prison sentences). As during the antenatal interviews, the support the young mums received from the baby's father could be considered to cover a broad continuum of support, from being significantly involved in family life, to providing no support what so ever. This was similar to the findings of the systematic review undertaken by McDermott et al (2004) who found that some mothers did maintain a relationship with the father of the child, some by cohabiting and some by having more fluid arrangements.

"He (partner) helps around the house, and if I'm worried about anything, showing interest in the pregnancy." *(Participant 10)*

"Yes, he (partner)helps me out with the baby. He doesn't live with us but he stays over a few nights in the week. He supports me by giving me

money because he works. And if I'm tired in night he'll get up with him, or he'll look after him." (Participant 20)

"None at all (support from partner), he's a total knob. I tell it like it is me. He doesn't help me out at all, he never looks after him, he doesn't see him." (Participant 21)

Proximity was an important factor to how much help was provided. It was obviously more difficult for the young women to receive practical support from their partner if they were not living with them. Four of the women (16.6%) lived at home with their parents, two lived with partners and four lived alone. As with the social support provided by parents, respondents identified instrumental socially supportive behaviours as being important elements of the support provided by their partners, such as doing practical things to help like providing financially or help with household jobs.

"I've only really got my mum and she's been really helpful and she's got two young children herself. Well I know how to look after children because the youngest is one and a half. My mum's close, just next door. She makes sure I'm eating and everything, makes sure I go to my antenatal. Or she came with me to one and she's like 'I'm concerned about her weight'." (Participant 6)

More specifically, financial support, or support in terms of material items or equipment was highlighted by young mothers as a common and important source of support provided by families and partners. Again, this reliance on financial support highlights the constraints that young mothers face in acquiring independence.

"Yes they've (parents) bought loads of clothes and everything and if I've been emotional, yeah, they've been alright." (Participant 10)

"They (parents) support me with everything, someone to talk to, money, everything really." (Participant 9)

"Financial support, they (parents) just do everything for me. Its really important to me". (Participant 3)

My in-laws will come round and his mother gives me advice I can turn to her, and she goes out and gets them stuff." (Participant 22)

Practical support with regular and frequent childcare was another important function of social support raised by the women. Arrangements for childcare were most commonly from informal sources. Young mothers' own mothers were by far the most important sources of help with childcare. Practical support with childcare appears to have a range of key functions, firstly it appears to provide the opportunity for women to maintain some kind of social life outside of their parenting role, secondly it allowed women to pursue training, education or employment, and thirdly it provided the important function of helping the young women to be able to cope with motherhood, particularly when they felt overwhelmed by their parenting role.

"My mum has him when I want to go out, and his other nana has him once a week, and his aunty has him once a week as well. They normally have him every Saturday or Sunday or a Friday. So I still get to go out with my friends and things." (Participant 6)

"I'm just scared of being on the flat on my own, but my mum says she'll come round all of the time, and take her if I feel stressed out and look after her for a couple of hours. ." (Participant 14)

"I am at college 4 days out of 5. I just sorted it out with my mum, she looks after the baby some days, then my boyfriend's mum looks after the baby some days and so does my mum's friend. I prefer it that it's someone who I know." (*Participant 16*)

"If it's like cold and I don't want to take him out, she'll have him. She has him in the evening if I want to go out with my mates. She has him a couple of nights in her room so it gives me a rest. I think I would have found it different if I didn't have my mum." (Participant 20)

Again this highlights the value and importance placed on the young mother's own mother's in terms of providing instrumental childcare support, that they feel comfortable with. As the next quote reveals this can sometimes provide a reciprocal arrangements in terms of the young mother providing childcare if there are younger siblings in the household, and demonstrates a relationship or cooperation and mutual support.

"My mum she has (baby's name) on a Friday night so I can out, but once (partner's name)'s out she won't have her at all because I'll just go up there with her. My mum looks after her on a Friday and I look after my little brother on a Saturday so she can go out, so it's fair really." (Participant 19)

Issues of trust and the importance of the role of the family in providing childcare were highlighted. Formal sources of childcare were treated with more suspicion, and this will be explored this in the next chapter in relation to how childcare can impact upon young mother's opportunities to escape social exclusion:

"Don't trust them (Formal childcare providers). I wouldn't want to leave my baby with someone else." (Participant 6)

"(Worker for TP Team) was telling me that they've got a women who can come in your house and look after the baby while you go to bed, but I wouldn't have any of that. I didn't fancy it and it's not as if I need it." (Participant 6)

7.9 Emotional support

The first phase of the study revealed that many services provided emotional support to young mothers, and yet the emotional support they received from their informal network was most commonly described as being the most important source of emotional support to them. Participants described the strands of emotional support provided informally by families and partners. Similarly to the antenatal interviews almost all the women experienced positive support from their mother, and considered their mother to be their most important source of emotional support. Emotional support was extremely important to the young mothers as they were experiencing a great many changes within their lives and needed someone to share these experiences with and to seek reassurance and advice.

"He (partner) supports me with everything, anything I need him for. Or if I need someone to talk to he's there. If I feel worried, money, just everything I need all through the pregnancy." (Participant 9)

"My mum tries to be there for me to talk to, and if I need things she'll buy them for me. She does help me out. My mum's the main person who I talk to ." (Participant 8)

During the antenatal interviews around two-thirds of the women were still in contact with the father of the baby, and most described the relationship as being emotionally supportive. Only three mothers had no contact at all with the father of the baby. On the whole, participants identified that the support they received from their partner was unique, in that it was someone else who was going

through the same thing as they were, with as much interest in and concern for the new baby, as they themselves had, a sense of someone else 'being there for you' or providing a sense of safety in terms of someone else to share the responsibility and the worry. Safety and trust are key elements of social capital.

> *"In a loving way, knowing he'll be there. It's definitely knowing someone's going to be there for you. It makes you feel a lot better anyway." (Participant 2)*

> *"When we got to antenatal he's asking questions and wanting to know more and excited about being a dad, really interested in everything. He takes note of my weight and everything. I don't know, I suppose its having someone who's going to be doing the same thing as you, like together, its like a different support." (Participant 6)*

7.9 Informational support – Lay knowledge versus professional

Mothers also appeared to be the main source of information and guidance about pregnancy and parenting. This suggests that young women want information about childbirth and childrearing, and in the absence of the provision of information from formal services, some are relying on word of mouth:

> *"I would like more information on pregnancy and childbirth, because it's my first one. My mum's told me loads because she's had five, but I would rather have my own point of view on it." (Participant 11)*

> *"I would have found it helpful to have some information about parenting and how to look after the baby, I didn't get anything like this and really I just had to learn it off my mum." (Participant 21)*

The two quotations above suggest a desire for independence, and opportunity to find out information for themselves, outside of the family network, as well as also a potential gap in the provision of information on parenting for young mothers. Again there is a strong desire for independence, and a further barrier identified in terms of information.

> *"I didn't want to go on my own to the antenatal classes. I didn't really want to go to a group of people that I don't know, on my own. I would if someone could have come with me. I mostly got that (information about parenting) from my mum." (Participant 20)*

However, although some young mothers commented that they would have liked more information from formal service providers, they appeared to place a greater trust in the information they received relating to childbirth and childcare from lay sources than from professional/medical sources. Perhaps the young mothers felt they were unable to ask the health professionals the questions they would have liked to about childbirth and parenting, whereas they felt more comfortable to discuss it with their own mothers. As discussed earlier in relation to young mothers' experiences of health professionals, there seems to be some evidence in their accounts of a paternalistic relationship between young mothers and health professionals. Young mothers seem quite passive in their contact with formal services by not asking questions for example, but rather just waiting to be told important information.

Experiential learning was an important source of information about childrearing; many of the women had had experience with younger siblings:

> *"I do know basic things because I used to mind my little brother when I was younger, but there will be things I don't understand. My mum and my midwife have told me quite a bit." (Participant 8)*

"They've not really spoke to me about the birth yet at the moment it's stuff about my weight. But, erm, I already know what I'm doing in there anyway, what drugs I'm having and stuff, because I've been to a birth with my mum. I went when she had my little sister. It was frightening, I thought I'm not having kids, its disgusting'." (Participant 14)

7.10 Socialising support

There are clearly many positive aspects associated with bonding social capital. A third of participants commented that they felt they received enough support from their friends, or that becoming pregnant had not changed their relationship with their friends. Also respondents felt that they did not particularly feel that they received a great deal of support from their friends, but that that didn't feel they needed it. In some cases, the socialising element of support possibly provided by friends did not seem particularly important to them, instead they valued the support they received from their family or partner as being more important. The support they received from family members in terms of childcare, in order to socialise, can be considered to be illustrative of bonding capital, in that it allowed this kind of support to be accessed.

The following extracts highlight a common theme relating to socialising support. Friendships appeared to deteriorate when friends no longer perceived themselves to have common or even similar life circumstances. Whereas mothers who did start to attend social support groups, were able to forge new friendships with other mothers, albeit who were not necessarily teenage mothers, on the basis that there was a common experience. In addition, those young mothers who were able to maintain friendships with their original friends throughout the pregnancy, were able to do so more effectively when the friends themselves were also young mothers. It seems that common experiences may be important in maintaining the relationship, as well as whether the young mothers were still able to identify with their previous network of friends. These common experiences may also have a role in helping them to cope with

mothering and motherhood, in that they are able to share advice and provide mutual support. Perhaps they may also feel more understood by these friends.

> *"Some of my other friends have children as well so we have things in common." (Participant 13)*

> *"My other friend is 8 months pregnant and we meet each other to do a bit of baby shopping in town and have a brew and catch up, It's really good. They've all been really supportive."* (Participant 14)

However, during the antenatal interviews around two-thirds of the participants commented on how little support they received from friends, or how becoming pregnant had had a negative impact on their friendships. In addition, they described how pregnancy had impacted on their life and influenced what activities they were able to be involved with:

> *"Apart from losing all my mates that is. It's not that much different, its just that I don't go out now."* (Participant 5)

> *"I am at school at the moment, so I see my friends everyday. I sometimes feel that I'm missing out on some things though, as I only go to school for one hour a day now." Mum replies "She feels like she's not as involved in things now, that she just hears about them off her friends." (Participant 16)*
> *"Yes, I feel a lot more tired, and have to stay in more after school rather than seeing my mates."* (Participant 16)

A number of the young mothers commented that they no longer saw much of their friends and now spent most of their time with family members or their partner. Their accounts suggest a sense of loss and an awareness that these relationships could not replace the support or function of friendships.

"I speak to them on the phone, but I don't really go out with them as much. I think it's because I feel I should just stay with my partner and not get out as much." (Participant 9)

"I've got none no more. Since I've been pregnant, that's it, they don't want to know. Its like they distance themselves from you. Because I've had my own flat since being like 17, we all used to sit in here, do you know. Since I've been pregnant it been like 'oh, I'll come and see you when I've got time' and you don't see them. I had a best mate and I've seen her for about 4 or 5 months. I think its cos I'm not smoking weed and its like they've got nowhere to chill. But I don't see none of them now. It's like I can't go out now, you know, cos I can't drink, its like they really don't invite me out, so I don't really see anyone. The only person I see is my boyfriend. I've not had no support from them (friends) none." (Participant 6)

"Well I don't really see them (friends) now, so am more friends with my sister, we go round each other's houses. My life's changed a lot, well you have to grow up don't you, socialising and stuff with my mates. I was a loud person wasn't I (indicates to mother), now I'm not really." (Participant 7)

"Well I see my mother and father in-law quite a lot because they come round, but I hardly have any friends around here. My relationship with my friends changed a hell of a lot. They were able to go out drinking and clubbing all the time and I wasn't. And they couldn't get over the fact that I was having a child and I weren't able to be a child myself. So there wasn't really any support there from them." (Participant 22)

"Only with my family really and my boyfriend's sisters. I do get bored half the time, very bored. I just stress out. Because I'm used to being out and about with the women and now I've stopped it, it does get to me at times." (Participant 8)

"I've not really spoken to a lot of my mates since I left school, I just go out with my boyfriend's sister and her kid. It's changed with my friends. I've got a few that still come round and see me, but not many. But out of my mates one's pregnant now, she's 6 months, the other one is 4 months, and two of them have already had babies." (Participant 20)

Two of the participants described how they had been able to forge new friendships with new groups, as their previous groups of friends no longer seemed to have anything in common with them.

"My life has changed, and it hasn't. Because I still go out at night and I take her out with me, until about 9:00pm. People say your life changes when you have a baby, but it doesn't, mine's just the same. I still go out at night, and she's nice and warm in that trolley because the Cosy Toes is furry inside, so she's not cold or nothing. I fell out with all them (friends), but I see my other mates, boy mates. Because its easy, I go on the Top Road, and my dad lives up there, so if she's getting tired I can just go to my dad's, or if she's hungry. My mates from before I don't really see anymore because they work and stuff and they're always busy, and they've got new boyfriends. I've not really seen no one since, I've not really been in school for nearly a year now." (Participant 19)

*"Its like I can't go out now, you know, cos I can't drink, it's like they really don't invite me out, so I don't really see anyone. The only person I see is my boyfriend. He lives in ******** (a different area of Manchester) so I only see him on a weekend cos he works all week. I've not had no support*

from them (friends) none. They (friends) all left me and then in the end it went worse. When I started showing, it was like, oh you can't come out, you can't drink. When you start showing they don't want you dancing about in a club with them, and that's when you start getting left. I'm back with my old friends from primary school now and they're great and quite supportive. Loads of my friends have babies, people who I've met through school, and through living here all my life. My friends who haven't got kids yet, that's when you realise you're on your own, you realise once you've had the baby. They stop inviting you out. You can't come because you've got a baby, you can't eat in a pub with a baby, so you stop getting invited, and you find out." (Participant 6)

This pattern continues post-natally whereby the young women do not appear to have much contact with their original peer group. Similar to the findings from the antenatal interviews, most young mothers found their relationships with their friends had deteriorated. Nearly all the participants described difficulties in terms of staying in touch with their original group of friends. Some were able to replace this by building a new social network with other mums they had met.

This important finding relates back to the concept of social capital and in particular bonding social capital. It is possible to see that the function of a young mother's social network that allows for the young women to take time out from motherhood and feel like a teenage girl again (who is not a parent) may be being limited by her existing social network or peer group. The existing peer group may no longer feel the bonding social capital that binds the friends together through shared experiences or characteristics is relevant, so they simply no longer fit into the group. As a result young women are in a position to strive for new friendships with other mothers, who they may not have considered themselves to have anything in common with previously. In this way social capital experienced by young mothers can be considered to be moving from bonding social capital (with its potential negative consequences such as keeping

people trapped within a network which may be stifling or dysfunctional, which can shut down opportunities, or apply peer-pressure for example), towards a more linking type of social capital, which may have implications for social inclusion as these types of social capital may have the potential to broaden opportunities and aspirations. These concepts will be explored in more detail later in the chapter.

There was a strong theme identified around diminished networks, leaving young mothers and young pregnant women at risk of feeling alienated and isolated, due to their limited opportunities for friendships. However there did appear to be some opportunities arising to forge new friendships. These new friendships were only in the very early stages in the majority of cases, but there may be some potential for these friendships to develop into more supportive relationships in the future, such as in terms of offering reciprocal babysitting arrangements.

7.11 Resilience and coping with adversity

What was most concerning was the sheer level of adverse stressful life events experienced by the young mothers in the study, and how they were able to cope with them on a day to day basis and continue with their parenting role. These included such experiences as domestic violence and ongoing arguments at home, having a previous abortion, having an alcoholic parent, potentially having the baby taken into care (which did occur in one case), having a friend die in a house fire and tragically, having a parent murdered. Many young mothers may be considered to have the 'wrong kind of social networks' – negative, antisocial networks. While social networks are most often considered to have positive benefits, in terms of preventing isolation and promoting well-being for example, for many of the young women in the study these networks more negative consequences. These particular network configurations suggest that they may prevent young mothers moving out of disadvantage and social exclusion e.g. such as out of an environment of crime. These types of difficulties can increase the young mothers' social exclusion. The following section is demonstrative of

how a person's network can play a role in either increasing a person's social exclusion or helping alleviate it through support of some kind.

> *"Yes my doctor's really good, what it is, I didn't want (baby's name), my mum was murdered, two years ago, and when I had him (the baby) I basically just didn't bother with him, 3 months it took me to get used to him. So everyone had a meeting and they tried to get everything that they wanted to just to try and keep me and (baby's name) together. My doctor, my health visitor, social services, aunty Joan (friend and carer). I can't say yet, about the future, do you know what I mean, because of my mum's murder and we're still waiting on that, they've not found my mum's body either, and I don't want to know, I've set it in my head now that we're not going to find her. I found out she'd gone missing, then I found out 2 days later that she was dead then I found out I was pregnant." (Participant 24)*

> *"And his sisters are brilliant with her, one of his sisters died though in (name of estate) in a house fire, her and her mate, and she couldn't wait for me to have the baby as well and then she never saw her. It was nearly 2 years ago she died, she was only 19." (Participant 19)*

> *"I've not really told anyone yet, but my neighbour on one side, she's really good. If she hears any shouting in the house or anything, she just knocks round and says 'come on, you're coming next door with me'. They're really good." (Participant 14)*

As well as highlighting the difficult environment the participant was living in, the quote above also highlights the importance of support from a neighbour in providing an opportunity to escape from arguments and confrontations within the home.

Two participants highlighted the stress they were experiencing as a result of involvement by Social Services, and the possibility of the baby being removed from their care. One participant from the first sample did in fact have her baby taken into local authority care, however it was not possible to follow this participant up.

> *"They just phoned me up one day and said they needed me to come in because they were thinking of taking her off me. It was like, wait a minute, they were doing it all behind my back. My mum's really helped me to sort it out……. She's really helped me which is great in some ways, but in some ways it's bad as it's stressing her out. She's really helped me."* (Comment re: Social Services) *(Participant 10)*

> *"I need to (smoke) because I thought I could quit, but I started smoking more since I got pregnant, because of social services. They are doing my head in. They've been in mine and my mum's lives all my life, you know, because she's got a drink problem. We've all just finally got back on our feet and they just butt their noses in at the wrong time. My mum and me made a deal that we would both cut down together, then we've both got each other's support. But recently we've both been smoking loads. I spend about £20 per week on them and that £20 could get me so much more. Social services have given me some advice, I know they are there to help, but sometimes they interfere too much." (Comment re: Social Services) (Participant 12)*

> *"Domestic violence, yes we've been through that in the past as well" (Mother of Participant 12)*

The three quotes above are illustrative of the impoverished and fragile networks in which young mothers own mothers are struggling to provide support and care.

The following participant had been placed on a protection order which prevented her from living in the same area as her parents. The young mother was clearly distressed about being moved away from her parents as it meant she was unable to see them as frequently, and therefore further diminished her social network.

> *"And then he said because she's been moved out of the area and everything, because of the police on the protection order, he said you're a bit out of my boundaries to be seen here, aren't you. Put it this way, I've changed doctors because he's a waste of space. She had the first initial appointment (with community midwife) but the midwife was more concerned about me and my state of health, was I an alcoholic, blardy, blardy bla. (Mother of Participant 12)*

The young women described an almost inevitable sense of 'just having to get on with it' in relation to the difficulties and ups and downs of their lives. Many demonstrated a kind of resilience to the day to day hardships they faced. This was notable in the women who were no longer with their partners, and there was a sense that they expected that they were just going to have to make the best of it by themselves. The negative relationships that some of the women had with their previous partner was a considerable source of stress with partners sometimes ignoring them in the street, being involved in crime and violence, and harassing them, culminating in them becoming involved in complicated legal battles: Also, although some partners can be a source of support in caring, they can also become a primary source of stress for young mothers.

> *"My partner, not a lot, he doesn't work at the moment. I don't think he can be around the baby, if you know what I mean. He wanted the fun bit, and then when he got all the hassle of nappies and everything he just didn't want that bit. I'd like him to come home, and if he was in the house just to*

play with her, or bath her. If he was here I'd be able to talk to him, but he's never here so I just get on with it." (Participant 22)

"I do want to move out but (partner's name) can get a house because he's 19, he's already got rid of one flat, he had to move out because some man hacked his door down, I weren't there. I would like to live with him, but if he starts robbing again, then I'm not going to be with him anymore. I've told him." (Participant 19)

"No, I don't want any support from him (baby's father), I don't want him nowhere near him, so if I went through maintenance and I thought to myself, I'm going to turn round and get it stopped. I don't care if they stop my money. So they said, why what's wrong and I said this, I went through social services because he tried to take him away from me, through a solicitor to try and get an injunction on him, they wouldn't do it, I was absolutely fuming. And then I read up on the child maintenance, right if they pay maintenance then they're allowed to see them. I was like Wo! You can sod off you're not having him. I've got a new partner now, I'm with someone else and he was constantly phoning the mobile saying he was a paedophile and all that, and everything, and I mean everything, he was creeping around my house, him and his mates. I just don't want to know anymore." (Participant 24)

"I can't rely and depend upon anyone around me at all, all I can ask for is help and advice when I need it, but apart from that I just depend on myself." (Participant 1)

The comment above may be indicative of a kind of enforced coping, not by choice but by design because of limited support networks. This in turn indicates diminished and impoverished networks that can therefore expose women to social exclusion.

The diminished support networks relate to social capital as the above findings demonstrate that the networks are not necessarily providing a basis for trust, co-operation and safety. They offer little in the way of benefits or support. They illustrate the lack of traditional norms of reciprocity and the expectations and obligation of parenting. Some of these relationships actually appear to damage stability and a sense of safety.

Seven of the young women also described periods in their lives where they had experienced considerable emotional distress or depression, either before or after the birth of the baby. In one case a woman had an overdose of antidepressants. These are clear examples which put the stressful backgrounds of the women's lives into context.

> *"I think I got that (depression) when my mum had my brother cos I lived at home then and I had to look after my sister when my mum went in (hospital) for my brother. There's only one year between them so I think I got depression, cos I had to go to the hospital and she had to discharge herself because I was so stressed out, to see to me. I said 'I can't cope'. It's a lot to cope with because there's like 6 of us, and I was looking after 5 and I was only 15 at the time." (Participant 6)*

> *"I ended up with post natal depression because I wasn't getting any help at all, and it just felt really, really strange. Yes I did get treatment for the depression, but because I didn't go and see the doctor for my 6 week check, I just kept avoiding them, my health visitor eventually made an appointment behind my back and literally just dragged me down there to the doctors, and it was only then that I found out why I was like I was, crying all the time, rejecting the baby. Before I had her I was not told that I could end up with it. I was worried that it might happen again, and I didn't get any help until (Health Visitor's name) came along." (Participant 22)*

"I did this (Edinburgh Post Natal Depression Scale) with (Health Visitor's name) the other day, and I think it came back as 18, so she was like, you have to go back to the doctor. So I went and now they've put me back on antidepressants. I can't have them in the house though. I was raped when I was 16, and so now I can't have antidepressants in the house because once I took them all and overdosed on them and ended up in Hope Hospital, so now I can't have them. I have to keep them at (friend and carer's) and I go up to her every night to get one." (Participant 24)

These kinds of traumatic life events would be sufficient to take their emotional toll on most adults living in secure and comfortable surroundings, but considering them in addition to the fact that these women are teenagers, struggling with the responsibility of becoming a parent, and living in poor environments on extremely low incomes demonstrates a remarkable resilience in the face of such adversity. However, while these adverse circumstances are almost experienced as the norm by these young women this is not to say that they were necessarily complacent. There was strong evidence of a desire for self-enhancement amongst the majority of the participants, as well as aspirations to achieve in some way and move beyond their grim circumstances.

7.12 Network vulnerability: Impoverished networks and over reliance

The size of the young mothers' social networks in relation to the different sources of support available to her may be of significance. For example, if the family disapprove of the pregnancy, or the partner does not wish to be involved, then straight away the young mother is left with virtually no support from the outset. Support from parents, friends and partners are fundamental to the young mothers' well being and ability to be an effective parent, but these networks can become vulnerable due to over reliance, and some of the negative consequences associated with social capital, and in particular bonding capital,

such as experiencing conflict or bullying, or shutting down opportunities or aspirations.

As a result of her family not wishing to be involved with the baby, this participant was clearly upset and worried about how she was going to cope with motherhood on her own. This particular participant also had very limited support from the baby's father, and no friends living in the area, so felt quite isolated and lacking in support generally:

> *"Towards the baby I feel positive, but I need to know about more groups, more people I can turn to, more things money wise, cause I'm going to be totally alone. If I'm alone with this baby and I was to become ill, have a temperature that bad that I can't get out of bed, who's going to look after my baby? Who's going to be there for me? As a single mum you can't depend on nobody, can't depend on friends, you can't depend on next door neighbours, you can't depend on people like that sometimes. A lot really as I've had to sacrifice a lot, but I mean, it's not the end of the world in my eyes. And it never has been, even though I been in the most worstest situations and had problems going on, I never thought it was the end of the world. At the end of the day the decision was mine, totally mine. Basically I've just had to handle it in the best way I know how. This is the support that needs to be looked up on. It's very serious, this is what I worry about, I just haven't got this kind of support. Most people have families around them, that's where families come into it, but I haven't got that." (Participant 1)*

Regardless of your point of view regarding the prevention of teenage pregnancies, it is impossible to deny that once a decision has been made by the young woman to continue with her pregnancy, then positive support and acceptance from parents and the wider social network are pivotal to the young woman and her chances of social inclusion.

As described earlier, bonding social capital is concerned with friendships or support networks between individuals with similar characteristics living in similar circumstances. A further example of the potential negative consequences of this type of social support was demonstrated when the young women described their experience of the support they had received from their friends since becoming pregnant. Where many young women had been excluded from their original peer group as they no longer 'fitted in' or could no longer join in the social activities that the groups enjoyed together, they no longer seemed to share common experiences with their peers. This highlights the importance of looking towards other means of social capital as a route to social inclusion, such as through opportunities to develop bridging and linking social capital.

Bonding networks comprise of friends and neighbours which are capable of providing mutual support and a source of social capital (i.e. resources that help women cope with motherhood and disadvantage, and of which emotional and practical support can be a part) seem to diminish for these women once they are mothers.

In a similar vein, it is likely that as many of the young women described getting no support from their partners (particularly as in 3 cases partners were in prison), the young women would be forced to rely even more upon their own mothers for support with parenting, as described in the next section:

> *"No (support from baby's father), probably I am missing out in a way, but when I decided to have the baby, I knew I was going to have to do it on my own anyway." (Participant 23)*

> *"No, I don't get any support, and I don't want any, we've just broken up so I don't want any support off him. The only support I get is off my mum. (Participant 12)*

"Well (partner's name), not a lot because he's in prison. Well I don't know if he is her father, but I class him as her father because he's been there for her. But my mum goes mad though because she doesn't like him. I used to go and see him in prison and he plays with her and I went to go and see him when she was new born and he dressed her and stuff, but he's not seen her much lately. And he stuck by me when I was pregnant, even if it weren't his child he still stuck by me. It's been nearly 2 years, that's my longest relationship (Participant 19).

The above quote illustrates again the problems of conflict within the network, and the potential problems that arise from partners being in prison, creating dysfunctional or negative networks.

" My boyfriends not out yet, he's out on Friday, and he's in jail. He's been there since (baby's name) was born, he wasn't there at the birth though because he was in jail. I got with him, and then I found out I was pregnant. He used to sing to her all the time, so she knows his voice." (Participant 19)

However, the participant who gave the quote above was optimistic about her partner being released from prison, and the additional support that would give her.

"I'm still with him (baby's father), but he's in prison. Yes, I get enough support for what he can give me, I get. And his family. He's there for me for what he can do." (Participant 6)

Although there were clearly strong, and supportive relationships between the young mothers and their own mothers, networks were often quite fragile simply because the young mothers were so reliant upon their own mothers for support with parenting. This was because other sources of support that are usually available to new mothers, such as from partners and friends, was largely absent. This meant that sometimes the relationship between the young mothers and their own mothers could become strained through over-dependence, and this was further compounded by their deprived circumstances, poverty, and stressful day-to-day experiences. Conflict and relationship breakdown further limit the young mothers' opportunities for social capital.

In some cases there appeared to be more tension within the home, where it was felt that perhaps the young mum's own mother was taking over the parental role, which could result in the young mum feeling pushed-out, criticised, or relinquishing their role as the parent to their own mother. The following extracts are interesting as they reveal some of the tensions experienced by young mothers who are still living at home with their parents. They are perceived as still being children, despite having a child themselves, and to some extent adopting the role of being a child and relinquishing responsibility to the parent.

> *"My mum said that if I give her that £17 a week, she said I'll have (baby's name) if you want to go out at night, but I said no, because she's trying to make out that I don't look after her and stuff. When (Family Support Worker) comes its like oh my god, me and mum argue like mad. I say mum leave her crying, she's crying over nothing, and my mum picks her up. Its like when she was new born, I would say leave her crying, there's nothing wrong with her, if she really starts choking and stuff its different, like she does now, she makes herself choke, then you pick them up. I told my mum to take (baby's name) to take my little brother to school on Wednesday morning, she dressed her in weird clothes, and when she got back I dressed her again. She said what are you dressing her again for, I*

said, because she looks stupid what she was wearing. When she's got trackies on, she puts shoes on with them. You don't wear shoes with trackies, I'm like are you mad. She's thinks I'm dead petty, but you don't do that you put trainers on with trackies. She's not fashionable." (Participant 19)

"I keep getting letters through the post asking about her father, but I don't know who he is, and they keep sending letters. My mum always opens them; a letter came asking who's the father." (Participant 19)

The following quote actually refers to the extended family rather than specifically the young mother's own mother, but is still relevant and useful example to demonstrate the desire for independence.

"His aunty, (partner's sister) she's like put your bottles on like this, put the teats on the bottles like this, put him this, have you got a spare set of clothes, if she takes him out he comes back in a different set of clothes than what I've sent him out in. Wipes, even down to changing the wipes that he has, she puts her own wipes in, she's gone out and bought everything, basically her bedroom is like a baby room now, she's gone out and bought loads of toys, different dangly things, loads of nappies, talcum powder, stuff like that for when he goes up. It is just invading, it is so invading, and you just want to do your own thing. If you get it wrong, you get it wrong that's the way of learning, and they are just in your face too much. I feel like saying just go away. Give me some time on my own, I just want to do it on my own. My family's not like that though." (Participant 6)

However there was an interesting contradiction between feelings of independence amongst the young mothers, whilst in reality they were dependent

upon their parents for instrumental support in terms of housing, financial support, childcare, and support in meeting their most basic needs like food. For example, some young mothers who were too young to move out, although they would like to, had become reliant on the instrumental support they were receiving associated with living with a parent, and so were able to relinquish responsibility to the parent and adopt a more childish role.

> *"I think I'm doing everything wrong that I do, because people keep saying don't do it like that all the time. I do want to move out but (partner's name) can get a house because he's 19, he's already got rid of one flat, he had to move out because some man hacked his door down, I weren't there. I would like to live with him, but if he starts robbing again, then I'm not going to be with him anymore. I've told him." (Participant 19)*

> *"If I'd been a bit older when I'd had her I would have liked to move out, obviously I couldn't live on my own at 15, but I wish I'd have had her in my own house, cos then I wouldn't have got used to it. If I moved out now she's just start playing up because she's used to me and my mum. But now on a Friday she won't settle with my mum, because she's used to me and she sleeps in my room with me now. I asked (Family Support Worker) if I could go to some house thing where they support young mums with babies. Because when my mum's around I'm like mum, do this do that, when I'm on my own I do it all myself. But my mum doesn't realise this, she thinks I'm dead lazy, so. But some people said I was better off not to go as some of the mums there are smack heads and stuff. Well I want to get my own house, but my mum won't let me because she says I don't do enough for (baby's name). I'd rather live with my friend than on my own. I've got a boyfriend." (Participant 19)*

So it could be considered that some young mothers may be having their opportunities for social inclusion limited by the very fact they are unable (for

financial reasons) to leave home and establish their own family independently of their parents. These negative aspects of social support can detract from the ability of the networks to alleviate stress and help with coping, and may exacerbate these problems and increase vulnerability.

However living at home does appear to increase possibilities for social inclusion through the provision of childcare thus creating opportunities for education or employment. There are examples of women within the study who were continuing to work or go to college, whose parents were supporting them to do this through the provision of childcare.

Also, while there are tensions in wanting to become independent and not being able to financially, living at home with parents does help prevent young mothers from living in poverty or disadvantage due to the provision of financial or material resources. Again this is suggestive of the vulnerability and fragility of the social capital that young mothers have at their disposal, because it seems to be fundamental to their needs.

Summary

Young mother's own mothers are able to provide support in terms of a place to live, everyday living, self-care and material necessities. Mothers provide the building blocks of everyday life. In some cases there is still a traditional parent/child relationship with the mother taking care of both her child and the grandchild. Partners appear to have a less significant role in providing support in many cases, with fewer partners involved in providing support.

Support to the young mother in parenting is provided by a range of wider family members including the partners parents, and siblings, as well as their own siblings, and in a some cases the young mother's father, play a role in providing.

Support received from partners or the father of the baby appeared to have less significance to the young women in this study, than the support they received from their family, or in particular, their mother. Proximity and accessibility was a key issue in terms of the support young mothers received from their partners, which was often limited if the partner was not living with them or was in prison.

Despite many young mothers having aspirations to return to college or employment, childcare was raised as a barrier, due to a lack of trust in professional childminders. This lack of trust in professionals, and a preference for, and belief in, individuals within their own informal network was echoed in relation to informational support. Lay, or experiential knowledge (such as relating to child birth or child care) was often heeded over and above that of health professionals.

For many young mothers their network of friends diminishes during pregnancy or after the birth leading to an over reliance on a small number of network members, in the main the parents or young mother's own mother. Though there may be some opportunity to forge new friendships outside of the original support network, which may constitute linking social capital, there was only limited evidence of this.

Young mothers impoverished networks led to an over-reliance on a few network members; this could place strain on the relationship between mothers and daughters, and limit the young mother's opportunities for independence, making informal networks ever more vulnerable.

Many young mothers experienced relationships within their informal network that could be damaging and did not provide a basis for trust, cooperation or safety. These damaging relationships that the young mothers were tied into through their disadvantaged circumstances demonstrate the importance or providing opportunities for bridging capital, to help overcome the effects of social exclusion.

There was an undercurrent of adversity and disadvantage in the young womens' narratives, which provided a rich context to the issues discussed within the study concerned with the government's approach to tackling teenage pregnancy.

7.13 Barriers to social inclusion

This section of the Findings explores how social support may constitute a social capital resource to enable young mothers to overcome social exclusion. It is useful to return to Levitas's (1999) model of social exclusion to consider some of the barriers to social inclusion.

7.14 Material deprivation and redistributive discourse (RED)

Levitas's (1999) material deprivation explanation of exclusion whereby individuals are unable to access the basic material or financial resources to allow them to participate fully in social life was apparent amongst the accounts of some of the young women. They described circumstances whereby poverty prevented them from accessing the basic support that could facilitate their inclusion:

> *"At the moment, because of splitting up with my boyfriend, I've not been getting out of the house much. I've just been staying over at my mums. I've got no money to get places. If I had money to get places I'd be able to get out and do things."* (Participant 12)

> *"I would expect as a teenage young mother that the TP unit should have some funding, there's plenty of teenage mothers and they could be literally homeless like me, penniless like me. For example, what would people do, they could be left starving." (Participant 12)*

This theme was further identified by exploring the financial support that was provided by the TP Team. Negative comments were made about the team concerned with the lack of resources that the team had available to them, in

terms of supporting young mothers financially. A few young mums were disappointed or confused as they had expected that the TP would have been able to offer them more physical or material support in terms of benefits or equipment etc.

> *"Even though as a TP Team, I should feel like they should have been there even more than a social worker was. We once had an interview and it was like they were saying they don't really have any funds. And there was this young girl who had like no money, no nothing, and she had a newborn baby and she didn't even have any money, for the baby, and all they could scrape for her was £10. Now I've been in the situation where I've had no money at all left, now my social worker helped me. She gave me a funding of £30 to help me. They told me they could help me with housing, we can help you with this, we can help you with that, all sorts of things. When it came down to it, there wasn't much support there at all really because they don't have any funds." (Participant 1)*

This respondent was clearly expecting that 'support' should mean financial support, but services are largely unable to provide this. Approximately half of the respondents described tangible, physical items of equipment that they had been given by formal service providers to help with the care of their children. Tangible items of instrumental support were highly valued amongst the participants.

7.15 Social integration discourse (SID)

The second explanation for social exclusion described in the Levitas (1999) model is the Social Integration Discourse, which is the predominant theme of the TPS, and simply suggests that the route to social inclusion for young mothers is through increasing their income through paid employment. Most of the women anticipated that the future would include returning to college or work, and to some extent saw their route to social inclusion, at least at some point in the near future, being concerned with accessing opportunities that could increase their

skills and income. Again, childcare was raised as a key consideration in deciding about how realistic it would be to achieve this. Childcare is obviously a key factor in enabling young mums to continue with their education, but many do not feel confidence in using professional child care.

During the antenatal interviews participants were asked about their ideas for the future, and long term plans, which were generally positive in nature. The ability for young mums to fulfil these ambitions is inextricably linked to the instrumental support that is available to them in terms of childcare that they feel comfortable with, and financial support. When thinking about the future most participants responded with specific ideas about formal qualifications or training they would like to undertake.

Nearly all of the young mums had ideas about what they would like to achieve in the future. Most of the participants wanted to go to college either to finish courses that they had started or start new courses, which does not fulfil the traditional stereotype of a young mum that is often portrayed in the media:

> *"I just need to get college finished. I've only got another year to do, but it won't take a year, and then I'm going to do mobile hairdressing, so I can't wait until I'm getting my own money and getting myself together, so when I've finished it and sorted out the nursery I should be fine then. There's one nursery round here that my sister uses that's really good, you've got to have a job to go to be able to use it. But then I don't know what age to put him in, but I'll just do it when I feel ready. I don't want to think about it yet." (Participant 2)*

> *"I know a bit about childcare through my sisters working and putting theirs, but I've not been given information myself. I wouldn't trust anyone else to look after him yet, he's too small at the moment. When he's older I would because I need to go back to college and work. I've not had any*

information about childcare if I go back to college, but its something that would have been really been good as it would have helped me to think about whether or not I wanted to go back to college." (Participant 21)

The social integration approach to tackling social exclusion, through paid employment did seem to have some resonance with the young mothers and was a common feature in their descriptions of how they viewed the future. However, how realistic this would be for most of them to achieve at any point within the next five years was questionable. As was rather succinctly put by one young mother:

"If I could go back to when I was 17 I wouldn't of had a kid then, because I was able to go out every weekend and I had a good job and now I'm lucky if I get out once a year. And I can't go to work so it's just really boring staying at home. Everyone thinks you can have a kid and still go out to work and do all this and that, but you can't. Its even worse because you're working 24 hours a day." (Participant 22)

However well meaning SID approaches may be, they fail to recognise the extreme and chaotic circumstance in which many young mothers are living. This study has documented some of the adverse experiences young mothers have faced in Salford, and the ongoing difficulties they are facing. The key point seems to be that motherhood can be a difficult and challenging time for all mothers, this is likely to be exacerbated for those mothers experiencing poverty and disadvantage. However, this coupled with being young and stigmatised can only add to the emotional trauma experienced by young mums. The adversity experienced by many of the women in this study goes someway to highlighting the difficulties with taking one approach to tackling social exclusion in isolation. For example, if we consider the SID approach, which is concerned with education and employment as a route to financial, if not social inclusion, you can see how a one size fits all approach is likely to have a very limited impact given

the extreme emotional and social barriers that are being experienced by many of the young mothers in this study.

7.16 Moral underclass discourse (MUD): Stigmatisation and taking Personal responsibility

Levitas's (1999) third explanation for social exclusion was focussed around a moral underclass discourse based around the public's perception of their suitability as parents, and concerned with their heavy reliance on government support for their subsistence. These two perceptions are an underlying theme of the TPS, deeming that young mothers are irresponsible to become parents at such a young age when they are supposedly emotionally incapable of effective parenting, and unable to financially support themselves and their child; both of which have then become bound up in concerns about young women's sexuality and loose morals, and have become popular themes within the media.

As has been demonstrated from the findings in the previous section, this type of discourse whereby young mothers have no desire to be included and actively choose to 'drop out' of society is largely unfounded, with almost all the young women not expecting to spend their lives confined to welfare dependency, but with significant plans or at least ambitions to escape this.

One of the consequences of this moral underclass discourse is to bring about a sense of inferiority or stigmatisation amongst young mothers that they are somehow inadequate parents and must always be in a position of proving themselves to be 'good mothers', and also to create a sense of discrimination amongst the general public towards young mothers for their irresponsible, immoral behaviour. Unfortunately this attitude can be encountered amongst the providers of the government-led services that young mothers need to access to help them to escape poverty and exclusion. This was described by a number of the young women taking part in this study.

Young mothers raised concerns about the quality of the services that they had received within primary and secondary care. Some questioned whether they had received a less high quality service because they were a 'teen mum'. Others felt staff had treated them with less respect because of their status. Many felt reluctant to access services such as parenting classes, as they perceived that other older or married mothers would be judgemental of them.

It is interesting that the issue of feeling stigmatised for being a young mother and subsequently receiving a less high quality service, were raised on four separate occasions when participants were describing their experiences of the support that they received in secondary care.

> *"I found them (antenatal checks) okay, but I think they need to separate the groups because when you go in there you get older people looking at you, like you know, my daughters that age, in the waiting room." (Participant 6)*

It is interesting that one social exclusionary experience for a young mother could include rejection by peers, rejection during the antenatal period through formal services and then to consequently build new networks post-natally so as to become included in a different world of 'mothers'.

> *"I think that when you go to different services, that just because you're a teenager they don't treat you as well as they do with older mums. Like with me, I was in hospital for ages and then they found out I had Strep B through routine tests, and the same thing happened with my friend and she got really ill when she came home from hospital. I think they just don't seem to care as much because you're a teenager, and older mums get better treatment. Me and my friend were talking about it the other day. All the young mums that we know end up getting something wrong with them and that doesn't seem to happen with older mums. They seem to check*

things more with older mums. They wouldn't tell me nothing at the antenatal checks they just told it all to my dad. They just gave all the information to my dad and he wouldn't tell me because he didn't want me to worry because of the strep B. but I'm glad now because it would have made me really upset." (Participant 21)

"Yes once when I went for the scan, one women she just checked the baby and then was like ok go, she wouldn't find out the sex for me, she just ignored us, she was quite nasty, because I was a teenager she was being quite funny. And I went for another scan and they told me."(Participant 19)

The review by McDermott et al (2004) also found that young mothers experienced a level of judgement and hostility across a wide range of social sites such as schools, education facilities, health, welfare and housing services in their neighbourhoods. Similarly to the findings of this study, the review by McDermott et al (2004) found that young mothers cared deeply about doing their best for their children and placed great significance on 'giving the baby a good start'. Many women tried to change their lifestyles and behaviours by giving up smoking and drinking. But this was undermined by a reluctance to seek professional support from health and welfare services for fear of being judged as being an inferior parent, this may go someway to explaining the low uptake in the young women attending the antenatal/parenting classes that were provided.

7.17 Self-fulfilment from motherhood

Perceptions of the life-changing nature of childbirth had become a theme during the analysis of the postnatal data. Only one negative comment was made expressing regret for the early childbirth. All the other responses to this question were extremely positive, highlighting how their lives had been enriched by the

experience, and led to increases in their self-confidence and self-esteem, helped them to be more focussed, and to learn new skills.

> *"My life's better now I think. I don't know, its just bringing something to life, its nicer." (Participant 20)*

> *"My life has changed, it is more busier and better. Don't know, you just become a mum over night; you become dead mature and just do your shopping and it's great. If I've not got him I'm not organised. If he's not with me I don't know what to do, right what do I do? Who do I go and see? It's made my life loads better. I think I'm more outgoing now, I think I do more stuff, and make more of an effort to do things."*(Participant 6)

> *"My life has changed a lot, I can't really explain. Its good though, I like, I like the responsibility and someone needing me, I like the feeling of it. Its definitely better, there's nothing bad." (Participant 2)*

> *"Yes my life has changed, I don't know, but I suppose it's the responsibility. But I feel like I've adapted to it really well." (Participant 16)*

> *I've found it easier than I expected actually. I was worried about weaning but that was easy as well. I just read up on it all in books and leaflets and done it my own little way. (*Participant 9*)*

> *"I think its changed better, but I think its give me something to do, something to look forward to, so I'll have something to do, to be occupied. I'll have to go out and go to different groups and stuff, so its changed for the better I think. Its made me more mature in a way, cos otherwise I'd probably still be sat here smoking weed wasting my life away." (Participant 6)*

So, the women demonstrated personal responsibility in wanting to become socially included through their descriptions of their ambitions and plans for the future, and through their desire to be 'good mothers'. They did not appear to be deliberately excluding themselves or wishing to drop-out of society, which is somewhat at odds with the Moral Underclass discourse that is prevalent within the TPS. The women did not wish to be confined by welfare dependency, but to seek self fulfilment and meaning from motherhood. Almost all the women described how their lives had changed for the better as a result of their new mothering role. The findings revealed a number of positive outcomes that the young women themselves identified and valued about being a mother: the responsibility, having a new role or purpose, being busy and organised, learning new skills, meeting new people and making positive lifestyle changes. The young mothers had developed a sense of pride in themselves and what they had achieved, that they may not have felt before, in how they had been able to adapt to their new role, and they valued feeling needed.

Summary

This final section of the findings has used the Levitas model to explore how the social support young mothers are receiving from both formal and informal sources may constitute a social capital resource to overcome social exclusion.

Having such limited resources so as to be unable to join in with mainstream society (RED) was described by many young mothers within this study, particularly in relation to housing. SID is one approach to overcome this, and currently the approach favoured by the government. Social inclusion through paid employment fails to take into account the complexities of the lives of these young mothers. Despite this most young mothers clearly had aspirations for the future. The MUD approach to social exclusion had some resonance with the young mothers in this study. What was most important was the young mother's desire for social inclusion through their role as a 'good mother' and the sense of pride and well being in themselves they had developed through becoming a

parent. There is something of a contradiction between human agency and taking responsibility on one hand, and the role of social forces in shaping their circumstances on the other.

The findings suggest that the barriers to social inclusion are many and varied. They include poverty and low incomes (including lack of owner occupier status), lack of skills, unemployment, lack of education and educational opportunities, impoverished neighbourhoods/ poor housing/ housing problems, family breakdown, crime, lack of participation in social life, access to public and private services, feelings of stigmatisation or inferiority (in relation to confronting formal services), and social isolation.

Chapter 8 – Opportunities for the future social inclusion of young mothers

The aim of this thesis has been to examine teenage mothers' experiences of social support and social capital with particular reference to New Labour's emphasis on the TPS as a means to tackling social exclusion, particularly in relation to improved support. The key objective of the study has been to understand the role of social support networks in the lives of young mothers and to explore to what extent they represent a form of social capital that is instrumental in overcoming social exclusion.

The study has drawn on two sources of data to evaluate the TPS in promoting social inclusion. Firstly, data provided by a range of teenage pregnancy service providers through structured interviews regarding formal support provision, and secondly, in-depth, semi-structured interview data with young mothers about their experiences of social support.

The chapter will consider the implications of this study, firstly in terms of adding to the existing knowledge regarding young mothers and social support, and its implications for practice and the delivery of services, etc, and secondly regarding young mothers and social capital. The chapter will then discuss the findings in the light of adding to the current knowledge regarding young mothers and social exclusion, in relation to the TPS and the implications for government policy.

8.1 What does this study add to the current knowledge in the field of teenage pregnancy, formal social support and social capital?

In light of the findings from this study, along with the evidence from wider literature, it is essential to consider what we can expect formal services to provide at a local level. Many services were experienced by young mothers as being useful and supportive, in particular the TP team was most often cited. Services were found to be supportive if they provided practical, instrumental and

material types of support; were approachable; holistic; and provided tailored one to one support. In addition services provided an information resource for young women, particularly about benefits and housing, which helps them to manage financially, and may go some way to increasing their social inclusion.

There is no doubt that the young mothers received a comprehensive array of different high quality health and social care services, from a series of committed and caring professionals. The young mothers described how they valued the opportunity to talk to someone about their concerns about pregnancy, or their child, and to receive reassurance. What appeared to be lacking from some of the formal health services, was the time they were able to give to the young mothers to provide information and advice in a friendly and informal, practical, non-judgemental way. Providing informational support within a flexible, holistic service during the young mother's pregnancy and early stages of the child's life, may be more resource intensive initially, but will most likely reap rewards in the longer term. Participants highly valued the instrumental support they received from formal services.

Some informational type support provided by services in this study was not perceived as useful or relevant to young mothers in the context of the complexities of their lives. Many young mothers were also reluctant to access services for fear of being stigmatised or criticised. Many of the young women included in this study described feeling vulnerable and unconfident about accessing services for fear of being viewed as an unfit mother. This highlights the importance of providing a flexible service that can be tailored to meet the individual needs of this vulnerable group, whereby staff are sensitive and understand the particular circumstances and needs of teenage mothers. If a young mother feels more confident receiving support in her own home, or within a group that is exclusively for other young mothers, then perhaps this is what should be provided. It is unlikely that simply giving young mothers information in the same way that is provided to all other mothers and pregnant women, is likely

to have the desired effect. For this reason understanding the nature and importance of social support to new and young mothers may be a key role for service providers.

The young mothers greatly valued the material, physical and instrumental support they received, and yet what formal services were able to provide was actually very limited. The term 'support' was primarily concerned with emotional and informational support, not financial or material support.

Formal services have an ideal opportunity to provide support that could be considered to constitute bridging and linking social capital by helping to develop networks between people who may not necessarily be alike (living in similar circumstances or experiencing the same pressures), or between service users and providers, where power relationships are not equal. However, evidence from this study suggests that many services are not being delivered in a way which young mothers feel comfortable to access, or communicate with, or most importantly, trust. This may reflect the levels of social exclusion already felt by many young mothers, and appears to limit the effectiveness of services in acting as a conduit for the production of bridging social capital for young mothers.

This study has presented evidence of a lack of peer support for young mothers, both in terms of formal service provision with the purpose of developing peer support, and in terms of young mothers' experience of deterioration in their friendships. During pregnancy, less than a quarter of participants had attended social support groups provided by services but those that did, found it was a positive experience and an opportunity to meet other mums, share experiences and learn new skills. For those who attended the support group regularly, they obviously valued the experience in terms of helping to fill their week with activities, and to give them the opportunity to develop social support networks. However most of the participants expressed a reluctance to attend groups. . Socialising support from friendships often ceases for women as the pregnancy

becomes more established, which is likely to exacerbate feelings of social exclusion. However the extent to which we can expect services to fill the gap in social support left by friendships is questionable.

The opportunity for services to provide socialising peer support groups for young mums may be particularly relevant when it is considered that the supportive relationships that many young mums have with their friends often change during pregnancy. Most women described how becoming pregnant had had a negative impact on their friendships. Deteriorating relationships that many pregnant women have with their friends is clearly an important issue to them and indicates that a key element of their social support network is missing. It appears to be the element of social support that allows them to be able to chat about things unrelated to the pregnancy, to take their mind off their circumstances and to be 'one of the women' again, to be carefree, and to feel 'back to normal', that may be lacking from many young mums' lives. However some bridging social capital appeared to be present in terms of young women who had accessed community groups, and developed new friendships with a wider network of women, who, although they could be considered to have similar characteristics as themselves may have come from different communities or be of a different age group. These new friendships were outside of the women's own, original social network, and so could be considered to be a form of bridging social capital.

What was less evident was the potential opportunities for women to access linking social capital, which is the form of social capital that Szreter (2005) argues is the most important form of social capital in bringing about social inclusion. How does the support women are offered provide them with opportunities for education and skills and a route out of poverty, in order to further their life chances? The data suggests that although many young women wish to return to education and employment, their opportunities for social inclusion will always be limited by their status and circumstances as a teenage mother, in particular childcare will be a huge barrier to their future.

It is questionable to what extent services are able to foster the development of social support through social activities and whether it is even appropriate to expect them to do so. However it does seem apparent that it may be an area of support that is lacking in young mothers' lives. In some senses the 'support network of services' goes some way to delivering social inclusion, in that they are providing advice about income, housing and opportunities for further education etc. However, the services appear to be missing an excellent opportunity to foster social inclusion through the lack of development of socially supportive networks amongst groups of peers, which will have implications for the health of the young mothers.

Utilising formal services as a vehicle for developing social support and increasing social inclusion in young mothers may be an excellent ideal, but the extent to which this is being achieved is questionable. It might be more realistic for policy makers to be considering alternative methods for the development of social support at the community level, rather than through formal service provision, or whether it is even at all possible or appropriate for formal services to take on this role. In this way, the formal services provided for young mothers in Salford can be considered to go some way to ameliorating the effects of social exclusion.

Many of the women did not appear to have access to formal facilities or resources to facilitate mothering and social inclusion. The childcare provision, training and education packages and employment opportunities need to be both appropriate and acceptable to young mothers in order to make them a realistic prospect. Despite many young mothers having aspirations to return to college or employment, childcare was raised as a barrier, due to a lack of trust in professional childminders. This lack of trust in professionals, and a preference for, and belief, in individuals within their own informal network was echoed in relation to informational support. Lay or experiential knowledge (such as relating

to child birth or child care) was often heeded over and above that of health professionals.

In a number of cases young mothers described how feelings of stigmatisation had affected their experiences of using formal services. Despite this most young mothers have very clear and positive ideas about the future and what they would like to achieve in terms of their education and employment. This goes someway to demonstrating that formal services are supporting young mothers towards increased social inclusion through the routes of education and employment. However, more could be achieved if greater consideration is given to the complexities facing young mothers in terms of how they value their role as 'mothers' particularly given society's constant criticism of them and the dichotomy they face between wishing to be a 'good mother' and also to be economically independent. Services provided by the state could do more to promote social inclusion through providing a sense of positive motherhood and self-fulfilment in the mothering role.

8.2 What does this study add to the current knowledge in the field of teenage pregnancy, informal social support and social capital?

Young mothers' own mothers provided support in terms of a place to live, everyday living, self-care and material necessities. In this sense mothers provide the building blocks of everyday life. In some cases there is still a traditional parent/child relationship with the mother taking care of both her child and the grandchild. Partners appear to have a less significant role in providing support in many cases, with fewer partners involved. Proximity and accessibility was a key issue in terms of the support young mothers received from their partners, which was often limited if the partner was not living with them or was in prison. In terms of wider family members, the partners' parents, and siblings play a role in providing support to the young mother in parenting.

There was considerable evidence of practical and instrumental support, emotional support and informational support being provided through the young women's own informal networks. There was a noticeable distinction between the value placed on lay knowledge versus that placed on professional or medical knowledge. Families, especially mothers, were key resources for young mothers in providing support, along with partners, and in some cases friends or other individuals sharing similar characteristics in providing social capital.

This study has demonstrated that informal support networks delivered a range of positive benefits in terms of helping young mothers to manage motherhood through helping with basic needs such as financial support, food and equipment, childcare, accommodation, social activities and emotional support, and so in that way can be considered to be providing a form of social capital. However, it is questionable to what extent this informal bonding type social capital can facilitate a route to social inclusion. Bonding capital may help women to cope with motherhood and their sense of social exclusion, it can be a very valuable source of support as it helps mothers to 'mother' and provides a sense of self-fulfilment in the role. However, bonding capital may not in itself be enough to necessarily promote social inclusion and help women improve their social and economic position and escape poverty.

As described in the previous chapter, there were clearly strong and supportive relationships between the young mothers and their own mothers, which were key to their experiences of social exclusion and motherhood. However, as other sources of support that are often available to older new mothers, such as from partners and friends, were often missing within the social support network, the relationship between the young mother and her own mother could become strained, because of the level of dependence young mothers had on their own mothers emotionally, financially, and instrumentally. This was further compounded by the complexities of their lives associated with living in areas of multiple deprivation. This finding has clear implications in terms of local service

provision, and bridging this gap within the social support network. This study demonstrates the fragility and vulnerability of young mothers' social networks as the limited size meant that often mothers were the only source of support.

Informal support networks, particularly mothers, provided the young women with a range of opportunities to support their parenting in a positive way, such as childcare, information and emotional support, which can go some way to protect against social exclusion. But they face many obstacles to inclusion including living on a low income, lack of access to transport etc. These informal social networks are limited by the impoverished circumstances of those individuals inhabiting them (e.g. through substance abuse, mental illness, criminal activity and prison). Therefore the very factors that are associated with disadvantage might be limiting the effectiveness of the social networks, thus shutting down opportunities for the young mothers to escape exclusion. So while networks may provide resources to cope with motherhood they may not provide teenage mothers with resources to improve their social and economic situation and advance social inclusion.

This study found that there are a number of negative consequences of this bonding social capital, as the relationships in themselves can create added stress and anxiety for the young mothers as they become vulnerable due to over-dependence. These informal networks commonly featured conflict and relationship breakdown, experiences of mental illness, involvement with both petty and serious criminal activity and the justice system and child protection. These factors can contribute to the problems in dealing with motherhood, and may actually prevent people from accessing resources that may facilitate social inclusion.

Many young mothers experienced relationships within their informal network that could be damaging, and which did not provide a basis for trust, cooperation or safety. These damaging relationships that the young mothers were tied into

through their disadvantaged circumstances demonstrate the importance or providing opportunities for bridging capital, to help overcome the effects of social exclusion. There was an undercurrent of adversity and disadvantage in the young womens' narratives, which provided a rich context to the issues discussed within the study concerned with the government's approach to tackling teenage pregnancy.

Therefore, just because people have informal social networks they may not necessarily be supportive, and, moreover, even supportive networks may not have the capacity to provide social capital (i.e. profitable connections) – the two are not interchangeable. Therefore social capital can be a consequence of social networks but this may not necessarily be so. In the main, the young womens social networks appeared to lean heavily towards the bonding type of social capital as they were concerned with networks of individuals with shared norms, values and characteristics. These networks help people to cope with stressful events, which goes someway to buffering against the effects of social exclusion, but as outlined above, they can create their own stresses and anxieties in themselves.

Many types of support exampled by the young mothers represent bonding capital, which helps them to cope with the demands of motherhood and living in disadvantaged circumstances. However, it seems from their accounts that many of their network members are equally disadvantaged and similarly socially situated to the participants. They are thus limited in terms of the bridging support they can offer that might provide an opportunity for social inclusion. Despite this, childcare could be one practical example of how these networks could function to support the route to social inclusion, as could can encouragement and positive feedback.

Networks are effective in terms of helping mothers to cope with parenting and their sense of social exclusion, but they do not necessarily promote social

inclusion. Bonding capital can be a very valuable source of support if it helps a mother to 'mother' and provides self-fulfilment. The social capital available to young mothers does not necessarily translate into social inclusion, as it offers limited opportunities to improve their life chances as it is essentially bonding capital rather than bridging or linking social capital. Therefore, the social capital experienced by young mothers offer limited opportunities for the life chances of these individuals. Informal social networks can enable young mothers to cope on a day-to-day basis with the hardships of motherhood and poverty, but they are fragile and do not equate to a form of social capital that provides opportunities for translation into social inclusion.

8.3 Implications of the findings for social exclusion and government policy

The TP strategy described the importance of providing increased support for young mothers through formal services in order to aid their social inclusion, but the research has demonstrated how some of the real economic, material difficulties in which many of the young women are living severely limit this possibility. The findings suggest that the barriers to social inclusion are many and varied. They include poverty and low incomes (including lack of owner occupier status), lack of skills, unemployment, lack of education and educational opportunities, impoverished neighbourhoods/ poor housing/ housing problems, family breakdown, crime, lack of participation in social life, access to public and private services, feelings of stigmatisation or inferiority (in relation to confronting formal services), and social isolation.

The Third Way approach appears to add to the social exclusion experienced by young mothers. The TPS fails to value motherhood and caring responsibilities among teenage mothers and the opportunities this affords in terms of self-fulfilment etc. This relates to Levitas's critique of current government policy rooted in a model of social exclusion in which the key element is labour-force attachment. This final section of the thesis will consider the theoretical implications of the findings from this study within the original conceptual

framework of the study by using the Levitas' model to explore how the social support young mothers are receiving from both formal and informal sources may constitute a social capital resource to overcome social exclusion.

To revisit Levitas's (1999) model of social exclusion; this model identifies three approaches to explaining social exclusion. The model puts forward a number of differing approaches or discourses to addressing social exclusion based around material deprivation, social integration through paid employment and finally a moral integration discourse. The SID approach is the Government's principal discourse within current policy, and will be explored first.

8.3.1 Social integration discourse

During pregnancy, almost all the women had ideas about what they would like to achieve in the future. Most of the participants wanted to go to college either to finish courses that they had started or start new courses. Nearly all the women felt positive about the future, although some admitted to having worries or concerns about how they would cope and whether they'd get enough support. Most of the participants had ideas about their future and what they would like to achieve beyond having a child. This does not fulfil the traditional stereotype of a young mum often portrayed in the media. However, it could be argued that the fact that so many of the young mums felt optimistic about their ability to achieve qualifications and careers is demonstrative of the fact that they are socially included, and yet in reality, it is questionable how easy it would be for them to access training and jobs, whilst also being a mother, in terms of being able to negotiate the practical and emotional complexities of this and finding and affording suitable childcare.

The point appears to be that the young mothers in this study do not have the support that is specifically relevant to their needs, in terms of flexible learning packages and childcare. However, teenage mothers in this study did not lack determination regarding their circumstances. Instead what they appeared to lack

was resources and opportunities, and in some cases confidence. Whether women wanted to work or return to education or training, the combination of very little money and caring for a child meant that these life 'choices' were not easily available. Therefore young women's life choices were overwhelmingly defined by their poor socio-economic circumstances.

To some extent services are able to provide opportunities for social inclusion through education and training. As argued by Luker (1997), a good starting place would be to provide high quality publicly subsidised day care for poor children. So the SID approach to social inclusion does not appear to be an appropriate solution for young mothers, on its own. Education may be one route out of poverty promoted through government policy, but in isolation, due to the multiple complexities of young mothers' lives.

8.3.2 Redistribution discourse

The Third Way discourse has seen a more explicit focus on parenting as a designated area of policy intervention (Wasoff and Hill, 2002). Parenting practice has been pushed to the centre stage of the social policy curriculum, with perceived consequences for society generally. In policy contexts, the term 'support' has traditionally implied direct help in the form of material benefits (as in child support, income support etc). Levitas (1999) and Fairclough (2000), however, have noted the New Labour Government's shift from concern about material poverty, towards a focus on moral 'poverty' and cultural pathology. This is particularly relevant to the findings from this study where young mothers highlighted that they had higher expectations of what could be delivered by services in terms of material and instrumental support, when, in fact, informational support, or advice from professionals was the most commonly provided support. Thus, in relation to parenting, the use of the word 'support' in policy interventions tends towards education and advice from experts, inculcating

norms and values in the practice of parenting that are perceived as fractured in contemporary society, rather than financial support.

The notion that parents must be supported in their parenting practice has sustained a variety of initiatives that aim to widen access to advice and guidance on childrearing. For example, Sure Start aims to involve local communities in supporting parents and to improve parents' access to information and advice (Barlow et al, 2007). Yet, the findings from this study present the family as the main and most valued source of support and advice in motherhood, over and above that of formal services or professionals, which many young mothers felt were inaccessible or not relevant to them. Perhaps policy should be concerned with developing social support networks amongst mothers at the community level, with less focus on providing 'expert' advice, which can be alienating, stigmatising and moralistic.

Services can provide the means to better manage one's health, to learn new skills, or even to find employment, and in this way 'buffer' against the effects of social exclusion. Current policy approaches appear to ignore the reasons why young mothers and other parents living in poverty often find it difficult to raise their children according to typical middle class standards. A combination of entrenched poverty, stress and poor living conditions make choices about education less of a priority than surviving on a day-to-day basis. So, perhaps we should return to a conception of social inclusion in terms of relative poverty, where material resources are so seriously low as to exclude people from everyday living patterns, customs and activities.

In terms of the implications for government policy which aims to reduce the social exclusion of young mothers, tackling inequality and addressing poverty and social injustice would appear to be an ideal starting point for all families living below the poverty line. Not only would this improve social outcomes for these families, but would also reduce the stigma experienced by young mothers that is

associated with current policy initiatives which aim to home in on teenage mothers for attention.

8.3.3 Moral Underclass Discourse

Having such limited resources so as to be unable to join in with mainstream society (RED) was described by many young mothers within this study, particularly in relation to housing. SID is one approach to overcome this, and currently the approach favoured by the government. Social inclusion through paid employment fails to take into account the complexities of the lives of these young mothers. Despite this, most young mothers clearly had aspirations for the future. There was an interesting contradiction between human agency and responsibility on one hand, and the role of social forces in shaping their circumstances on the other, in terms of the reality of living in such deprived circumstances, and practicalities of being able to access opportunities which may facilitate a route to social inclusion. These findings reveal a contradiction between policy approaches to tackling teenage pregnancy, and the actual experiences, views and values of the very young mothers, who the policies are being targeted at.

This study demonstrated a range of positive outcomes for young women associated with early motherhood, including an improved sense of self confidence, purpose and direction, and making positive life changes such as stopping smoking or taking drugs, and improved relationships with their family. These findings were congruent with the wider literature (e.g. Wilson and Huntington, 2005, Duncan, 2007). The young women in the study demonstrated considerable personal responsibility in wanting to be socially included through their role as mothers, and their desire to be good mothers, as well as through their ambitions and plans for the future which invariably involved furthering their education and skills as a means to social inclusion. As stated at the beginning of the thesis, critics claim that the 'better support' component of the TPS is underplayed. But policy reformulation needs to go beyond a restoration of the

balance between the two policy arms; prevention and support. Rather, there needs to be a refocus on the value of parenthood in itself, both socially and for individuals. For teenage parents, this might focus on the positive experience of becoming a mother, and on young parents own resilience and strengths. Education and employment for young parents should be recognised as components of parenting (which could also include 'full-time' mothering at home), rather than as a return to individualised, rational economic planning where children are seen as an obstacle. Certainly, stigmatising policies directed at the assumed ignorance and inadequacy of teenagers are inappropriate (Duncan, 2007). This thesis has found that many of the young women felt proud about the ways in which they were bringing up their children and felt positive about being a mother. Motherhood provided a positive identity and a source of self-worth and social legitimation.

The young mothers in this thesis were able to reflect on and describe their experiences of becoming a mother in an extremely positive light. They described how their lives had been enriched by the experience, and led to increases in their self-confidence and self-esteem, helped them to be more focussed and to learn new skills. In this sense, the young women could be considered to have a very positive social identity, and that they felt a greater sense of worthlessness before becoming mothers. Perhaps in some ways they considered themselves to be more excluded in terms of the trajectory of their lives before becoming pregnant. This may be due to the sense of a positive identity they have within their own community, and the stigmatisation they experience tends to be from outside of their own networks.

The findings from this study go someway to supporting the earlier critique of the government's TPS. The young mothers had a positive conception of motherhood as an opportunity for self-fulfilment and brought meaning to their lives. They experienced hope and opportunities when becoming mothers, and were keen to provide opportunities and a better life for their children. On the whole, they were

striving for a way out of dependence with a strong desire to be good mothers for their children, which is contrary to the moral underclass discourse running through out current policy. These young mothers can be viewed as an example of a group who are being limited by structural opportunities within the socio-political environment. This was further exacerbated by the evidence of the young women's feelings of inferiority or stigmatisation when accessing formal services, where in some cases professionals were deemed to have a negative attitude towards them in term of their status as a young mother.

8.4 Limitations of the study

Having revisited the main findings of the study and explored the implications of them, it is necessary to consider the study itself, how it contributes to the existing body of knowledge, the strengths and limitations of the methods used, and areas for further research.

The aims and objectives of the study have been refined by a series of trial and error. The original research objectives described an exploration of the 'efficacy' of the TPS in supporting social inclusion. Having now experienced the examination process it has been possible to reflect on the appropriateness of this language within the original objectives of the study, and how it could very much highlight tensions between the positivist and interpretivist approaches to data collection in the study. At the outset of the study these objectives seemed achievable and realistic, but during the process of the undertaking the research and examination, I have changed the way I approach and think about the nature of research. As such it is recognised that it is not possible to produce generalisable results about 'efficacy' from this research paradigm, however it is possible to explore individuals perspectives in relation to the social exclusion and that this provides valuable knowledge or understanding.

When adapting the model for use before commencing the semi-structured interviews during Phase 1 of the study, it became apparent that additional

categories would need to be added to the model. These were concerned, firstly with the access arrangements for young mothers to be able to obtain the social support services which were not included in Barrera's model as it was designed for use with individuals receiving support rather than with services who provide it. Secondly, an additional category was needed that was concerned with negative interactions that may be experienced between service providers and young mothers. Barrera's model failed to take into account any interactions that could be perceived as being negative or unhelpful, something which may be relevant to interactions between services (which could be perceived as being authoritarian) and service users, but may be equally relevant to individuals completing the ISSB. Just to reiterate, these categories were added before commencing interviews and systematically included and so will not affect the reliability of the study.

One limitation of Phase 1 of the study is that it is subject to bias, given that perspectives have only been gathered from service providers, about the services they purport to deliver. Service providers could have an interest in presenting the services in a more favourable light. However it was anticipated that this would be accounted for during the second phase of the study where the perspectives were sought of young mothers into their social support needs and the extent to which this is being met through service provision. In this way, the two distinct phases of the study complimented one another in terms of contributing to a holistic picture of social support. In addition, the phase 1 empirical work can be considered to have added quality to the second phase of the empirical work with young mothers by informing the methods undertaken and the validity and reliability of the research tools developed for collecting the data.

One of the main limitations with the methodology used in Phase 2 was the high 'lost to follow-up' rate amongst the participants between the initial and follow up interview. It could have been anticipated that there would be some difficulty in tracking down the whole sample during this momentous life event. However, the

full extent of the proportion that could not be traced could not have been fully anticipated. What was interesting was that the service provider (TP Team) who initially helped with the recruitment to the study, were also unable to trace the young mothers, and when approached for more up to date contacts details, were only able to provide the original contacts.

This would suggest that the participants were no longer in contact with the Teenage Pregnancy team, or at least had not been for some time. It is difficult to establish 'lost to follow-up' rates in other studies of teenage mothers in the literature, however there does appear to be a consensus that the area itself is a difficult topic to research, due to sensitivity and difficulties in attaining a sample (Whitehead, 2001). This might be explained by the transient, chaotic lives of many young mothers, and the fact that these young women were being researched during a period where in every aspect of their lives they were experiencing a period of extreme change.

The sample was recruited whilst attending for routine antenatal appointments at the hospital. It is unlikely that any bias could have occurred during this recruitment as young mothers were approached on a weekly basis, as they turned up for their appointment, until a sufficient number had been recruited. Only one young woman declined to take part in the study. Although there may be a small number of young mothers who never attend formal services during pregnancy, it is unlikely that as this sample were recruited through the antenatal service that they would differ in any way from the general population of young mothers as the vast majority of young mothers do attend for antenatal appointments in order to access the ultra-sound examination. If there are a proportion of young women who never attend antenatal appointments and who are not represented in the study, it is unlikely that there would have been any practical way of accessing them and recruiting them to the study other than possibly through snowball recruitment.

Attrition bias occurs when the characteristics of the participants who were lost-to-follow-up differ from those in the remaining sample group, which could have implications for the reliability of the findings. In this case it could be argued that the young mothers who were impossible to follow-up may have had more hectic lives than those who it was possible to trace, or that they may have been receiving less social support. As it was only possible to follow-up 22% in this study, it seems probable that these young women may have had slightly better social support networks, or were at least still in contact with the TP team. However, when it came to recruiting the new sample of young mothers, the names of potential subjects were put forward by the Health Visitor. No bias is likely to have affected this group as they were approached by the Health Visitor during a routine visit to see if they would take part in the study, and none of the young women refused to take part. There is a possibility that the Health Visitors may have selected women who they considered to be appropriate to take part in the study. However, there was not a sense of this when interviewing the women in the new sample. They were certainly experiencing a range of differing circumstances, and had had very differing experiences. If bias has occurred at this stage, it is likely that it has been accounted for by the wealth of good quality data it was able to collect about women, following the birth, which it would not have been possible to do otherwise, having lost most of the original sample.

The method for selecting participants to the study through opportunistically approaching them at an antenatal clinic has been useful in allowing for a broad cross-section of the young mothers at various stages in their pregnancy to be included in the study. However one of the methodological problems with the study may have been allowing family members, partners, or friends to be present during some of the interviews, as it may have led to an element of bias in the participants' responses to some of the topics of discussion. But more positively, allowing friends and family members to be present during the interview may have added to the richness and depth of the data collected and helped to add to our understanding of the young women's experiences of pregnancy and the support

available to them. It may also have dissuaded the young women from taking part in the study at all, if they had been asked to attend alone, and so for these reasons it seems as though it were the best solution in this case.

Upon reflection from the examination process if became clear that alternative quality criteria should have been explored and applied during the process of the research that were more appropriate to the epistemological position of the study, rather than focussing only on the concepts of reliability and validity. The rejection of reliability and validity in qualitative inquiry in the 1980's has resulted in a shift towards strategies for evaluating trustworthiness and utility that are implemented once the study is completed (Morse et al, 2002). Guba and Lincoln substituted reliability and validity with parallel concepts of credibility, transferability, dependability, and confirmability (Guba, 1981). Within these were methodological strategies for demonstrating qualitative rigor, such as the audit trail, checking back with participants during coding, categorising or confirming results, peer debriefing, negative case analysis, structural corroboration, and referential material adequacy. Guba and Lincoln similarly developed authenticity criteria that could be used to evaluate the quality of research beyond the methodological dimensions (Morse et al. 2002).

Guba (1981) states that while all research must have a 'truth value', 'applicability', 'consistency', and 'neutrality' in order to be considered worthwhile, nature of knowledge within quantitative paradigms if different from the knowledge in qualitative paradigms. As such each paradigm requires a different set of criteria for addressing rigour or trustworthiness. Whilst in quantitative research the goal of rigor may be internal and external validity, reliability and objectivity, Guba and Lincoln suggest that the concepts of credibility, transferability, dependability and confirmability are more appropriate to ensure 'trustworthiness'. It is also argued that the investigator must be responsive and adaptable to changing circumstances, holistic, have processional immediacy, sensitivity, and ability to clarification and summarisation (Guba and Lincoln, 1981).

The four areas of trustworthiness identified by Guba (1981) (credibility, transferability, dependability, and confirmability) will now be explored in more detail in relation to this study:

Credibility – rather than aiming to guard against competing sources of error that may confound an inquiry, naturalists may seek to confront such factors and explore the impact of them. This can be achieved through prolonged engagement at a site to overcome potential distortions produced by the presence of researchers, and provide the opportunity to test their own biases and perceptions. Persistent observation can be used to identify pervasive qualities as well as atypical characteristics. Other methods include peer debriefing, triangulation of a variety of data sources, member's checks to test interpretations, establish structural corroboration to ensure there are no contradictions in the data.

Transferability – naturalists take the view that it is not possible to generate 'truth' statements that have general applicability, but rather statements that are interpretive of a given context. During a study naturalists will: do theoretical/purposive sample, and collect 'thick' descriptive data to allow comparison of the contexts.

Dependability – naturalists are concerned with the stability of data, but must make allowance for apparent instabilities arising from differing realities. Methods to improve dependability include overlapping of two or more methods, stepwise replication whereby two separate research teams deal with the data, and to establish an audit trail.

Confirmability – the object of scientific inquiry is to establish the degree to which the findings are a function of solely of participants and conditions, and not of the biases of the researcher. With naturalistic investigation there is a move away

from the concept of investigator objectivity to data and interpretational confirmability. Methods to achieve this would include triangulation as mentioned above, and practicing reflexivity by being transparent about underlying epistemological assumptions.

It is argued that research is only as good as the investigator. Therefore creativity, sensitivity, flexibility and skill in using verification strategies can determine reliability and validity. The responsiveness of the investigator to identify whether or not a categorisation scheme actually holds and is kept, or is not working and then is changed, is key to this process. It is essential that the researcher remains open, uses sensitivity regardless of the potential of the findings that first appear. A lack of responsiveness is argued to be the greatest threat to validity. This may be due to a lack of knowledge by the researcher, overly adhering to instructions rather than listening to data, an inability to abstract, synthesis or move beyond the technicalities of data coding or to work deductively from previously held assumption (Morse et al, 2002). This was apparent during this study, where by the process of thematic analysis had to be undertaken for a second time using an entirely new process.

The aim of methodological coherence is to ensure congruence between the research question and the components of the method. The interdependence of qualitative research requires the question to match the method, which matches the data and analytic procedures. As the research unfolds the process may not be linear (Morse et al, 2002). This statement has proved to be fundamental to some of the limitations within this study, whereby a contradiction has been apparent throughout the process between the research aims and objectives and the methods, which I have reflected upon following the examination process. Yet Morse et al (2002) do proceed to challenge Guba and Lincoln's quality criteria by arguing that the concepts of reliability and validity are overarching concepts that can be appropriately used in all scientific paradigms.

As described earlier, the analysis of the data for this study went through a number of coding processes, before deciding upon the most appropriate method of coding and thematic analysis. However, even coding the data in this way was less than perfect, and the themes to arise from the analysis did not fit succinctly into the neat categories of socially supportive behaviour described by Barrera due to the mixture of formal and informal support being explored. For example the model could be applied easily to socialising support behaviours for both formal and informal sources, as well as to explore and draw out instrumental type support provided by formal services, so for these examples the model worked very well. When participants described the support they received informally from their family or partner they mainly described emotional types of supportive behaviour and instrumental type behaviours (such as financial support, or help with housework etc), so here it is possible to see that two of Barrera's categories overlapped. Similarly, informational support was primarily described, by the participants, in terms of what was provided for them by formal services. However participants' experiences overlapped somewhat with the Emotional Support category as participants described actions that they had found emotionally supportive that had been provided by some service providers. For these topics it was much more difficult to separate out the different categories of social support.

So it is possible to see that although the ISSB model has been extremely useful for categorising and analysing a range of socially supportive behaviours, it may be more applicable to the analysis of formal or informal social support as two distinct entities, rather than exploring them concurrently. The method of analysis has allowed the qualitative data to be analysed in such a way as to maintain the integrity of the stories of the young women involved in the study. It has allowed for richness and depth in the understanding of the complexities of their experiences. The analysis process has made it possible for the young women to keep their very individual personalities, as well as demonstrated that they do not consider themselves to be different from any other mother despite the dreadful

events that befall them (such as murders, fatal house fires, violent attacks on their homes), as it is presented in the context of their day to day lives.

Researching young mothers has the methodological problems inherent in trying to access a vulnerable group, who have commonly experienced social exclusion and stigmatisation, and for these reasons may be difficult to access and reluctant to 'open up' and become involved in a research project. However as Whitehead (2001) states:

"Research in this area is difficult to undertake due to the extreme sensitivity, and yet it is vitally important if we are to assist those embroiled in the stigmatisation process which leads to social exclusion." (Whitehead, 2001, p.437)

8.5 Areas for further research

Many of the participants in the study had positive aspirations about the future and ambitions to return to education and train for careers. It would be useful to explore further, through a longitudinal study, to the extent to which young mothers are able to achieve these aspirations and the facilitators and barriers that enable them to return to education or training in the longer term.

8.6 Conclusion

The study has contributed to the wealth of research around the topic of teenage pregnancy by locating it within the context of social deprivation, social exclusion and social support. This study has collated the views of young mothers about their diverse experiences. It has described their day to day struggles of parenthood, their experiences of stigmatisation, their heavy reliance on support from their families, the costs and benefits associated with accessing employment or training, the loss of friendships and the hardships associated with living in areas of multiple deprivation, including being victims of crime and violence. In particular the study has highlighted the levels of adversity young mothers face

due to their stressful day to day circumstances, an issue which is little understood by the public.

Barrera's (1982) model of socially supportive behaviours has been valuable in providing a structured theoretical framework in which to examine the nature of socially supportive behaviours being provided by services for young mothers. The model revealed gaps in the provision of socialising support amongst peers and the providion of services aimed specifically at building bridging and linking social capital. In addition it has been possible to identify that in some cases young mothers are relcutant to access formal services for fear of being judged as unfit mothers. Gaps in social support clearly exist. Formal services can go some way to delivering the social inclusion of young mothers, but on their own, current approaches are not sufficient, they can only help to ameliorate the impact. Additional social support opportunities provided through services could help to reduce some of the strain that can occur within the relationship between the young mother and her own mother as a result of over dependence.

This study has provided evidence of the considerable limitations of the TPS as intiatives aimed at increasing the inclusion of young mothers, which focus on inclusion through paid work or education may be unlikely to deliver the desired results on their own. Especially if approaches fail to recognise the importance of the role of mothering, and added complexities and lack of opportunities facing young mothers when deciding upon the costs and benefits of returning to the workforce. Similarly, this applies to government initiatives focussed around the provision of 'expert' advice in parenting. Services that appear to be based on the false assumption that everyone has equal opportunities to get involved are unlikely to bring about changes in the social exclusion of young mothers. For this reason young mothers inevitably remain trapped in poverty as the usual escape routes are limited for them. Likewise, the government's approach to targetting young mothers through policy, to promote the disasterous consequences of early childrearing, is doing little to help the social inclusion of this group, but can

actually be considered to worsening the situation. These types of approaches are damaging to the wider social environment and helping to create a situation where groups such as young mothers become an underclass. The conflicting expectations from government and from the young mothers' informal networks within the local community may adversely impact upon their experience of social inclusion.

Stigmatising young mothers through government policy fails to recognise and educate people about why young mothers choose early motherhood within the wider context of their lives. Such as recognising the value of motherhood and the sense of moral wellbeing, self-fulfilment and self identity it can bring about, when other avenues for 'belongingness' have been closed down by impoverished circumstances. Inequalities experienced by young parents are not as a result of having a child whilst relatively young, but are a preceding and ongoing fact of their lives. Becoming a parent at a young age can limit many young mothers' future lives and close down opportunities for future education, training and employment. However many of these young mothers grew up experiencing problems of multiple deprivation, and already had limited opportunities for the future. This highlights a deeper problem, the lack of opportunities and aspitartions for the future of many young women, particularly for those living in areas of multiple deprivation.

Although services are able to go some way to support the social inclusion of young mothers what is required is the further exploration of and acceptance of the cultural norms regarding early motherhood, in order maximise the social inclusion of this 'politically difficult' and often misunderstood group of individuals. The thriving, high quality support that most young mothers are able to access from their families should be recognised, celebrated and most importantly understood, as it shows their resilience in the face of considerable adversity.

A series of inter-related events appear to shape the extent to which individuals experience social inclusion or exclusion. These factors include family or relationship breakdown, conflict within the family or social network, lack of education, unemployment and housing problems. However there are support mechanisms that might prevent this or provide a 'step-up' out of social inclusion, such as bridging and linking social networks, formal organisations, childcare and education. Current provision is insufficient and is not tailored sufficiently to meet the needs of this group of mothers, with considerable barriers to accessing such support. The TPS could do much more to help young mothers realise their goals

Appendix 1: Interview Schedule for use with Service Providers – Phase 1

Section One: Background on the Service

1. What is the name of your service?

2. Please can you describe the service you provide?

3. Is your service provided in groups or one to one sessions?

4. For groups:

a) How many service users are in the group?
b) What is the criteria to belong to the group? (eg. Resident in a particular community, aged under 16 etc.)
c) How often do the group meet up?
d) Over what period of time have the group been meeting up to support each other?
e) What is the length of time individuals attend the group (turnover of members, cliques, a sustainable core of members etc)?
f) How does being in the group provide opportunities for the members to help/ support each other both within and outside of the group?

5. For one-to-one services:

a) What is the criteria to use the service (eg. Resident in a particular community, aged under 16 etc.)?
b) How many young people do you see on average per day or week?
c) How much time do you spend with a particular service user?
d) Over what period of time will you support a particular service user?

Section Two: Understanding the Nature of Social Support being Provided

6. Private Feelings:

a) Do you expressed interest and concern in the young persons well being?
b) Do you provide an opportunity for young people to talk about their personal, private feelings in confidence?

7. Material or Physical Assistance:

a) Do you loan or give young people material aid, such as: (Prompts: travel expenses, equipment, other financial support)
b) Do you provide young people with physical assistance, such as: (Prompts: childcare, giving young people a life somewhere, helping out with household jobs, attending stressful situations with a young person, other physical support)

8. Advice:

a) Do you provide young people with information and advice with problems?
b) If so, what sort of problems do you feel you are able to support young people with: (Prompts: health, emotional, relationships, social, housing, education or training, employment, financial, legal, other)
c) Do you provide young people with positive feedback about their ideas or things that they do?
d) Do you help young people understand why they didn't do something well?

9. Social Participation:

a) Do you provide an opportunity for young people to socially interact, have fun or relax?
b) Do you provide an opportunity for the young person to talk about their interests?

c) Do you provide activities to do with young people to help them take their mind off things?

10. Negative interactions:
a) Can you think of any situation where by an interaction between this service and a young person could be stressful or upsetting for the young person?

Appendix 2: Topic Guide for Interviews with Young Mothers - Phase 2

- Have you used any of the following services, and how did you find it?
  Prompts for interviewer:
  Sure Start Plus/ Teenage Pregnancy Team
  Antenatal checks
  Midwife
  Health Visitor
  GP
  Citizen's Advice Service
  Brooke Clinic
  Connexions
  Supported Housing
  Parenting classes
  Reintegration officer

- Which has been most and least helpful to you and why?

- Since becoming pregnant what kinds of things have services or workers helped you with?
  Prompts for interviewer:
  Information about pregnancy and giving birth
  Learning about being a parent
  Support in breastfeeding
  Contraception advice and provision
  Giving up smoking
  Postnatal depression
  Relationships with partner, parent or other family members
  Emotional problems
  Getting out of the house and meeting other young parents
  Going to school, college or work
  Getting benefits
  Housing
  Getting childcare
  Childcare costs
  Information about other helpful service
- How often do you:
  Visit friends and relatives?
  Attend group activities?
- Does anybody else help you to look after your child?
- If you do not use childcare for your child why is this?
- How has your life changed since becoming pregnant?
- How do you feel you have been able to cope with some of these changes?
- At the moment, do you have a partner?

- What kind of contact do you have with the father of your child, how does he help you with the pregnancy/looking after the baby?

- How helpful have your family been since they found out you were pregnant, what kinds of things do they help you with?

- How helpful have your friends been since you found out you were pregnant, what kinds of things do they help you with?

- Do you get any other help or support from anyone else in the community such as parent and toddler groups, or support from neighbours?

- What help do you feel has been the most important to you so far and why? Prompt: This could be help from your family, or from services like your GP or midwife for example.

- Is there anything else that you think could help you that would make a difference to your life?

- What would you like to do in the next few years? Prompt: What are your dreams and ambitions for the future?

Appendix 3: Information Sheet and Consent Form

Salford NHS
Primary Care Trust

Salford PCT, Sandringham House, Windsor Street, Salford, M5 4DG

INFORMATION SHEET

TEENAGE PREGNANCY AND SOCIAL SUPPORT PROJECT

You are being invited to take part in this project. Before you decide, it is important to understand why this is being done and what will happen. Please take time to read this information sheet. You may wish to discuss it with your family, friends or carers. Please ask if anything needs to be made clearer to you. You do not have to make up your mind straight away.

What is the project about?

Supportive relationships (with friends, family or community groups and services) are particularly important during times of stress or change, such as during pregnancy and early motherhood. The aim of this project is to have a better understanding of how support can be improved for teenage mothers.

What will happen if I take part?

With this information sheet you will also receive a consent form. You will have a week to think about whether you would like to take part in this project. If you decide 'yes' then the Teenage Pregnancy Team will pass on your contact details to me, and I will contact you to arrange a convenient time for us to meet up. We can meet up at your home, or any other place that you would find convenient.

The interview will take about an hour and will be very informal. You will be asked your thoughts about pregnancy and the support you have received. You will then be contacted again in about one years time for a similar follow-up interview.

Your conversation will be taped. This helps me to remember all the important things that are said. You will not be named on the tape and it will be kept in a locked cupboard. After the project has finished the tape will be destroyed. I will not tell anybody that you are taking part unless you want me to.

How will this help me?

Telling me something about your experiences will help us to support other young people better, in the future.

Who will you tell?

Nobody will know – except me (the researcher). If you want somebody to know you are taking part in the project, and you want me to help you tell them, then I will.

Do I have to take part?

No. Taking part is up to you. If you do not want to take part you do not have to give any reasons. If you do wish to take part but later change your mind, you can leave at any time.

What happens now?

If you do want to take part then let the Teenage Pregnancy team know and they will pass on your details to me. If you are not sure about taking part you have seven days to think about it. Please keep hold of this sheet so you have the information about the project.

What if I need to know more?

You can contact me, the researcher – Angie McLeod. My telephone number is 0161-212-4071. I am very happy to talk to you about the project and answer any questions. If I am not available please leave a message and I will get back to you.

TEENAGE PREGNANCY AND SOCIAL SUPPORT PROJECT

CONSENT FORM FOR INTERVIEWEES

Please answer the following questions by putting a circle around YES or NO.

1. I have read the information sheet.	YES	NO
2. I have had chance to ask any questions about the project.	YES	NO
3. I am happy with the answers to my questions.	YES	NO
4. I understand that I can leave the project at any time.	YES	NO
5. I agree to take part in this project.	YES	NO

MY NAME IS.....

CONTACT
DETAILS.....
.....
.....

PLEASE SIGN YOUR NAME HERE.....

TODAY'S DATE.....

PLEASE TELL US YOUR AGE IF YOU ARE A YOUNG PERSON AGED 18 OR UNDER.....

Appendix 4: Profiles of Teenage Pregnancy Services in Salford

Organisation	Teenage Pregnancy Team/ Sure Start Plus	Connexions – Teenage Pregnancy Advisor	Citizen's Advice Bureau – Teenage Pregnancy Advisor	Reintegration Officer	Brook – Teenage Pregnancy Drop-in clinic	Early Years Development & Childcare scheme for teenage parents	New Prospect Supported Tenancies provision for teenage parents
Location	Based within Salford Royal Hospital Trust	Central Salford	Based within Salford Royal Hospital Trust	Based within Salford City Council	Eccles town centre	Based within Salford City Council	Based within New Prospect Housing
No. of staff dedicated to teenage pregnancy	3 full time	1 full time	1 full time	1 full time	2 X 3hour sessions per week	Not applicable	1 full time
Service provision	Support, information, advice and follow up for young people who are pregnant and: Unsure whether to continue with their pregnancy Accessing termination of pregnancy services Continuing with their pregnancy Also provide additional midwifery, parenting, health visitor and contraceptive support	Each young person is allocated a personal advisor. The service supports young people in anything they want to achieve to give them the best start and remove any barriers that may be preventing them from achieving their goals. Support could be provided around employment or college or it could be around more complex needs like housing, which could be acting as a barrier to employment.	Works with expectant families providing general advocacy and advice services but to specialise in particular areas such as maternity grants, tax credits, child benefit, housing and overcrowding problems, Child Support Agency issues and domestic violence.	Provides home tuition and mentoring to pregnant teenagers and young mothers whilst they are absent from school. The service liases between the school and the pupil to ensure continuity in education, and that the young person is on a par with her peers educationally, whilst she is absent from school due to maternity leave.	National, not for profit organisation, which offers free, confidential pregnancy testing, sex and relationship advice and contraception to people aged under 25. The service is provided by doctors, nurses and counsellors.	A multi-agency partnership concerned with developing provision of high-quality childcare for children in the city. The partnership identifies childcare facilities for teenage parents. Teenage parents are given priority to return to training, education and employment. E.g. financial support for childcare and associated travel costs for 16 to 19 year olds to study in sixth form or college.	Works with young people who need to live independently to access accommodation in the right area for them. The service is able to help prepare the property: helping access furniture, arranging utilities and payment plans, and by negotiating with housing providers. Organisation G helps the young person to become established within their local community and to develop a

							knowledge of what services are available to them.
Referral criteria	Live in Salford Aged 19 and under	Aged 13-19, live in New Deal for Communities area	Registered to give birth at SRHT	Aged 16 or under	Under 25 In early stages of pregnancy	Aged 16-19, Return to education, have a child	Aged 16-25 seeking to live independently
Who can refer	Anyone, including self-referral	Anyone	Anyone	Via the young person's school education welfare officer or via Organisation A.	Anyone	Anyone	Anyone
How long available	2 years	1.5 years	2.5 years	4 years	12 years	1.5 years	8 years
Session length	Approx. 60 mins	45 mins	30-90 mins	120 mins	10 mins plus counselling session	Not applicable	45 mins
No. of sessions available	No finite number	No finite number	Until baby is 6 months old	Dependant upon case-load	Up to 3 counselling sessions	Not applicable	No finite number
Type of service delivery	One-to-one, plus one group activity available, appointment only, office hours only.	One-to-one, appointments available, drop-m available, office hour only.	One-to-one, appointment only, office hours only.	One-to one, available outside office hours/ term-time.	One-to-one, available outside office hours, appointments available, drop in available	Not applicable	One-to-one, available outside office hours, appointments available, drop in available.
Other comments	Each young mother is assigned a key worker. The team can provide support to other agencies working with teenage mothers	Building is attractive to young people, as fashionable decor, and informal etc.					The young person must agree to work with a support worker and undergo a full assessment of needs to establish which areas the young person may need support with

References

Allen I, Bourke Dowling S, 1998, *Teenage mothers: Decisions and outcomes*, Policy Studies Institute

Andrews et al 1977, in O'Reilly P, 1988, Methodological issues in social support and social network research, *Social Science and Medicine*, 26; 8; p.863-873

Antaki, 1994,in John T.E. Richardson (Ed.) 1996. *Handbook of qualitative research methods for psychology and the social sciences*. Leicester; BPS Books

Arai L, 2009, *Teenage Pregnancy: The making and unmaking of a problem*, Policy press, Bristol, pp.63, 70, 115-116

Atkinson P, 1992, *Understanding Ethnographic Texts*. Thousand Oaks CA: Sage

Baker and Taylor, 1997, The relationship between condition-specific morbidity, social support and material deprivation in pregnancy and early motherhood, *Social Science and Medicine*, 45; 9; 1325-1336

Barlow J, Kirkpatrick S, Wood D, Ball M, Stewart-Brown S, 2007, Family and Parenting Support in Sure Start Local Programmes, National Evaluation Summary Report, July 2007, Surestart Evidence and Research

Barrera M, 1982, Social Support in the adjustment of pregnant adolescents, in Gottlieb B Eds, 1982, *Social Network and Social Support*, Sage, p.69-96

Berkman L and Kawachi I, 2000, *Social Epidemiology*, Oxford University Press, p137-173

Berkman L and Glass T, 1994, in Berkman L and Kawachi I, 2000, *Social Epidemiology*, Oxford University Press, p137-173

Berkman L, 1984, Assessing the physical health effects of social networks and social support, *Annual Review of Public Health*, 5:413-32

Biehal at al, 1992, *Prepared for Living? A survey of young people leaving the care of local authorities*, National Children's Bureau

Birch, D. M. (1998). The adolescent parent: A fifteen year longitudinal study of schoolage mothers and their children. International Journal of Adolescent Medicine & Health, 10, 141–153

Blair, T, 1998, *The Third Way: new politics for the new century*, The Fabian Society, Lanan.

Blaxter M, Poland F, 2004, Moving beyond the survey in exploring social capital in Swann C, Morgan A, 2004, *Social Capital and Health: insights from qualitative research*, Health Development Agency

Bogdan and Birklen,1982, in Minichiello V, Aroni R, Timewell E, Alexander L, 1990. *In-depth Interviewing: Researching People,* Longman, Cheshire, p.87-106, 283-321

Bonnell C, Allen E, Strange V, Copas A, Oakley A, Stephenson J, Johnson A, 2003, Effect of social exclusion on the risk of teenage pregnancy: development of hypotheses using baseline data from a randomised trial of sex education, *Journal of Epidemiology and Community Health*; 57:871-876

Bonnell C, Allen E, Strage V, Copas A, Oakley A, Stephenson J, Johnson A, 2005, The effect of dislike of school on risk of teenage pregnancy: testing of hypotheses using longitudinal data from a randomised trial of sex education, *Journal of Epidemiology and Community Health*; 59:223-230

Botting B, Rosato M, Wood R, 1998, Teenage mothers and the health of their children, *Population Trends*, 93, Autumn

Bourdieu, P, 1986, The Forms of Capital in Baron, S. Field, J. Schuller, T. (eds.) (2000) *Social Capital - Critical Perspectives.* Oxford University Press.

Bowling A, 1991, *Measuring Health: A review of quality of life measurement scales*, Oxford University Press

Branch & Jette, 1983, in O'Reilly P, 1988, Methodological issues in social support and social network research, *Social Science and Medicine*, 26; 8; p.863-873

Breakwell G, 1990, Problems in Practice: Interviewing, BPS Books, Routledge, p.79-89 Source: Bryman A, 2004, *Social Research Methods 2nd Edition*, Oxford University Press, 417-434

Broadhead W, Kaplan B, S James et al, 1983, The epidemiological evidence for a relationship between social support and health, *Journal of Epidemiology*, 117:5:521-537

Brown and Sime, 1981 in Silverman D, 2001, *Interpreting Qualitative Data: Methods for Analysing Talk, Text and Interaction*, Sage Publications, London, pp13, 18, 32-35, 64-68, 88, 89, 95-97, 111-112, 225-251

Brown G, Harris, T, 1978, *Social Origins of Depression*, Tavistock Publications, London

Bryman A and Burgess G (Eds), 1994, *Analysing Qualitative Data*, Routledge, London

Brymen, 1988 in May, T, 1993, *Social Research: issues, methods and processes*, Open University Press, Buckingham, p.65 -110, 133 -151

Bullen E, Kenway J, Hay V, 2000, New Labour, social exclusion and educational risk management: the cause of 'gymslip mums', *British Educational Research Journal*, 26(4), 441-456

Bunting M, 2005, It isn't babies that blight young lives, *The Guardian*, 27/05/2005

Burchardt, T, Le Grand, J. & Piachaud, D, 2002, Degrees of exclusion: developing a dynamic, multidimensional measure. In Hills J, Le Grand J & Piachaud D (eds) *Understanding Social Exclusion*, 30 - 43. Oxford University Press

Burchardt T, Le Grand J, Piachaud D, 1999, Social Exclusion in Britain 1991-1995, *Social Policy and Administration*, 33(3) pp.227-244

Burghes L, and Brown M, 1995, Single Lone Mothers, *Social Policy Research*, Family and Parenthood, 84, October, Family Policy Studies Centre and Joseph Rowntree Foundation

Byner J, Parsons S, 1999, *Young people not in employment, education or training and social exclusion.* Analysis of the British Cohort Study 1970 for the Social Exclusions Unit

Byrne, D, 1999, *Social exclusion: Issues in society*, Open University Press, Buckingham, pp1-12, 63-98, 125-129

Campbell, C. Wood, R. Kelly, M, 1999, *Social and Capital Health* Health Education Authority. London.

Campbell, C, 2000, Social Capital and Health: contextualising health promotion within Local Community Networks in Baron, S., Field, J. Schuller, T. (eds.) *Social Capital – Critical Perspectives,* Oxford University Press.

Caplan, 1974, in Hupcey, 1998, Clarifying the social support theory – research linkage, *Journal of Advanced Nursing,* 27; 1; 1231-41

Carvel J, 2001, *The Guardian*, 2001, Britain ages as pregnancies fall, 23.3.2001

Cassel J, 1976, The contribution of the social environment to host resistance, *American Journal of Epidemiology*, 104, 107

Cassel.1974, in Hupcey, 1998, Clarifying the social support theory – research linkage, *Journal of Advanced Nursing,* 27; 1; 1231-41

Cattell V, 2001, Poor people, poor place, and poor health: the mediating role of social networks and social capital, *Social Science and Medicine*, 52(2001), 1501-1516

Children's Services Scrutiny Committee, 2007, *Teenage Pregnancy in Salford: A review of the provision of sex and relationships education within Salford*, Salford City Council, p.5

Cobb,1976, in Hupcey, 1998, Clarifying the social support theory – research linkage, *Journal of Advanced Nursing,* 27; 1; 1231-41

Cohen S and Syme L, 1985, *Social support and health*, Academic Press

Coleman, 1988 in Szreter S, 2005, *Health and Wealth: Studies in history and policy*, University of Rochester Press, pp.376-412

Coleman, J, 1990, *Foundations of Social Theory*. Harvard University Press Cambridge.

Cooper H, Arber S, Fee L, Ginn J, 1999, The influence of social support and social capital on health: a review and analysis of British data, *Health Education Authority*, 5-44

Coulthard, M. Walker, A. Morgan, A, 2001, *Assessing people's perceptions of their neighbourhood and community involvement (part 1)*, Health Development Agency, London.

Craven P, Wellman B, 1973, The network city, *Sociological Inquiry*, 43; 57-88

Croydon Community Trust, 1994, *The health of young mothers in Fieldway and New Addington,* Croydon Community Trust

Davies C, Downey A, Murphy H, 1996, *School age mothers: access to education*, Save the Children Fund, London

Dean, A. & Lin, N, 1977, The stress-buffering role of social support, *Journal of Nervous and Mental Disease,* 165, 403-417

Denzin N, Lincoln, 1994 in Silverman D, 2001, *Interpreting Qualitative Data: Methods for Analysing Talk, Text and Interaction*, Sage Publications, London, p250

Department for Education and Employment (DfEE), 1999, *Raising aspirations key to reducing teenage pregnancy* – Blunkett (press release) 14 June

DfEE, 1999, *Raising aspirations key to reducing Teenage Pregnancy* – Blunkett (press release), 14 June

DfES, 2003, *Every Child Matters*, HMSO

Department of Health (DoH), 2000, *The NHS Plan: improving health and reducing inequality*, DoH, London

DoH, 2001, *Consent - what you have the right to expect: A guide for children and young people*, Department of Health Publications, July 2001.

DoH, 2003, *Confidentiality: NHS Code of Practice*, Department of Health, Published 7/11/2003

DoH, 2003, *Tackling inequalities in health: A programme for Action*, Department of Health

DoH, 2004, *Choosing Health: Making Healthy Choices Easier,* HMSO

DoH, 1998, *Our Healthier Nation*, HMSO

Department for Social Security (DSS), 1999, *Opportunity for all; Tackling poverty and social exclusion*, Cm. 4445, The Stationary Office, London

DSS, 1999,*Opportunity for all: tackling poverty & social exclusion*, Cm 4445, The Stationery Office, London

Duffy K, 2005, *Social Exclusion and Human Dignity in Europe*, Council of Europe

Duncan, S, 2007, What's the problem with teenage parents? And what's the problem with policy*? Critical Social Policy,* 27(3); 307-334

Economic and Social Research Council (ESRC), 2004, www.esrc.ac.uk (retrieved August 2007)

Edwards J, Popay J, 1993, Contradictions of support and self-help: views from providers of community health and social services to families with young children, *Health and Social Care,* 2, p.31-40

Ermisch J & Pevalin D, 2003, *Who has a child as a teenager?* Paper provided by Institute for Social and Economic Research in its series ISER working papers with number 2003

Estivill J, 2003, *Concepts and strategies for combating social exclusion*, Geneva International Labour office

Fairclough N, 2000, *New Labour, new language*, London, Routledge

Fessler K, 2005, Adolescent mothers' perceptions and management of stigma, *Abstracts/* 36, 95-110

Fielding, 1988 in May, T, 1993, *Social Research: issues, methods and processes*, Open University Press, Buckingham, p.93

Foley, M., Edwards, B, 1999, "It is time to disinvest in social capital?", *Journal of Public Policy*,19 (2),141–73

Forbes A ,Wainright S, 2001, On the methodological, theoretical and philosophical context of health inequalities research: a critique, *Social Science and Medicine*, 53:6, Sept 2001, 801-816

Foster K, Lader D, Cheeseborough S, 1997, *Infant feeding Survey 6: 1995*, TSO

Geronimus A, 2003, Damned if you do: Culture, Identity, privilege and teen childbearing in the US, *Social Science and Medicine*, 57, 881-893

Geronimus, A, 1991, Teenage Childbearing & Social & Reproductive Disadvantage: The Evolution of the complex questions & the demise of the simple answers, *Family Relations,* 40.463-471

Giddens A, 1998, *The Third Way: the renewal of social democracy*, Polity Press, Cambridge.

Gill, R., 1996, Discourse analysis: Methodological aspects", in Richardson, J.E., (Ed), *Handbook of Qualitative Research Methods for Psychology and the Social Sciences*, Leicester: British Psychological Society

Gjerdingen D, Froberg D, Fontaine P, 1991, The effects of social support on women's health during pregnancy, labour and delivery, and the postpartum period, *Family Medicine*, 23(5), 370-375

Glaser B and Strauss A, 1967, in Bryman A and Burgess G, 1994, *Analysing Qualitative Data*, Routledge, London

Goode E, Ben-Yehud N, 1994, *Moral Panics*, Blackwell, Oxford, 87-103

Gottlieb B, 1985, Social support and the study of personal relationships, *Journal of Social and Personal Relationships*, 2; 351

Graham H, McDermott E, 2005, Qualitative Research and the Evidence Base of Policy: Insights from studies of teenage mothers in the UK, *Journal of Social Policy,* 35, 1, 21-37

Guba E, 1981, Criteria for assessing the trustworthiness of naturalistic inquiries, 29 (2) pp.75-91

Halpern, D, 1999, *Social capital: the new golden goose*. Faculty of Social and Political Sciences, Cambridge University. Unpublished review

Hammersley, 1992 in Silverman D, 2001, *Interpreting Qualitative Data: Methods for Analysing Talk, Text and Interaction*, Sage Publications, London, pp13, 18, 32-35, 64-68, 88, 89, 95-97, 111-112, 225-251

Hammersley, M, 1992, What's wrong with ethnography?, London, Routledge

Hanna B, 2001, Negotiating motherhood: the struggles of teenage parents, *Journal of Advanced Nursing*, 34(4), 456-464

Harden A, Brunton G, Fletcher A, Oakley A, Burchett H, Backhans M, 2006, *Young people pregnancy and social exclusion: a systematic synthesis of reserach evidence to identify effective, appropriate and promising approaches for prevention and support,* EPPI-Centre, Social Science Research Unit and Univeristy of London, Report March 2006

Hart N, 1993, *Sociology of Health and Medicine*, Causeway Books, 10-17

Hart, 1998, *Doing a literature review: Releasing the social science research imagination*, Open University Press

Hawe P, Shiell A, 2000, Social Capital and health promotion: a review, *Social Science and Medicine*, 51, 871-885

Health Education Authority (HEA), 1998, *Analysis of data on living arrangements from surveys on smoking and pregnancy*, 1994-1998

Henderson A, 1984, Interpreting the evidence on social support, *Social Psychiatry*, 19, 49-52

Hoggart L, 2003, Teenage Pregnancy: the government's dilemma, *Capital and Class*, 79, 145-165

Holmes, T & Rahe, R., 1967, The Social Readjustment Rating Scale,.*Journal of Psychosomtatic Resistance*, 11 (2) 213-218

House J, 1981 in Berkman L and Kawachi I, 2000, *Social Epidemiology*, Oxford University Press, p137-173

House J, Landis K, Umberson D, 1988, Social relationships and health, *Science*, 241, p.540-545

Huff, P,.1987.Psychological and Social Considerations in Adolescent Pregnancy Management, *Maryland Medical Journal.* 36 (11): 951-54

Humphreys J, 2001, Turnings and adaptations in resilient daughters of battered women, *Journal of Nursing Scholarship*, 33(3), 245

Hupcey, 1998, Clarifying the social support theory – research linkage, *Journal of Advanced Nursing,* 27; 1; 1231-41

Jewell D, Tacchi J, Donovan J, 2000, Teenage pregnancy, whose problem is it anyway? *Family Practice*, 17; 522-528

Jonge A, 2001, Support for teenage mothers: a qualitative study into the views of women about the support they received as teenage mothers, *Journal of Advanced Nursing,* 36(1), 49-57

Kidger J, 2004, Including young mothers: limitation to New Labour's strategy for supporting teenage parents, *Critical Social Policy*, 24(3): 291-311

Kiernan K, 1995, *Transition to parenthood: Young mothers, young fathers – associated factors and later life experiences*, Welfare State Programme, Discussion Paper WSP/113, LSE

Kessler R, Price R, & Wortman C, 1985, Social Factors in Psychopathology: Stress, Social Support, and Coping Processes, *Annual Review of Psychology* Vol. 36: 531-572

Klasen S, (no date provided) Social Exclusion & Children in OECD countries: some Conceptual issues

Lawlor D, Shaw M, Johns S, 2001a, Teenage Pregnancy is not public health problem, *British Medical Journal*, 323; 1428

Lawlor D, Shaw, M, Johns S, 2001, Teenage pregnancy and risk of adverse perinatal outcomes associated with first and second births: population based retrospective cohort, *British Medical Journal*, 2001 Dec 15, vol. 323, no. 7326, p. 1428-9

Lee M, Suhng L, Chou M, 1998, Association of parental characteristics with adverse outcomes in adolescent pregnancy, *Family Practice*, 15, 336-42

Levitas R, Pantazis C, Fahmy E, Gordon D, Lloyd E, Patsios D, 2007, *The multi-dimensional analysis of social exclusion,* Townsend Centre for the International Study of Poverty and University of Bristol, pp.9,10, 14-29

Levitas, R, 1999, Defining and Measuring Social Exclusion: A critical overview of current proposals, *Radical Statistics*, 71, Summer 1999, pp.10-27

Lincoln Y, 1995, Emerging criteria for quality in qualitative and interpretive research, Qualitative Inquiry, 1 (3), 275-289

Logsdon, Birkmer, Ratterman, Cahill, 2002, Social support in pregnant and parenting adolescents: Research, critique and recommendations, *Journal of Child and Adolescent Psychiatric Nursing*, 12:2, p.75-83

Luker K, 1997, *Dubious conceptions: The politics of teenage pregnancy*, Harvard Univeristy Press, Cambridge, p.3,9,12, 13, 41-42, 80, 106-111, 131-134, 176-182, 190-192

Luttrell, W, 2003, *Pregnant Bodies, Fertile Minds: Gender, race and the schooling of pregnant teens*, Routledge, New York

Lynch J, Davey Smith G, Hillenier M, Shawn M, Raghunathan T, Kaplan G, 2001, Income inequality: the psychosocial environment and health: comparisons of wealthy nations, *Lancet*, 358 (9277), 194-200

MacDonald R, Shildrick T, Webster C, Simpson D, 2005, Growing Up in Poor Neighbourhoods: The Significance of Class and Place in the Extended Transitions of 'Socially Excluded' Young Adults *Sociology*, 39(5), pp.873-891

MacLeod A, Weaver A, 2003, Teenage pregnancy: attitudes, social support and adjustment to pregnancy during the antenatal period, *Journal of reproductive and infant psychology*, 21:1:49-59

Marmot M Wilkinson R, 2001, Psychosocial and material pathways in the relation between income & health: a response to Lynch et al, *British Medical Journal*, 322, 1233-36

Mason J, 2002, *Qualitative Researching*, Sage, London, pp3, 8, 15-18, 26-27, 32-36, 52, 56-60, 62-66, 175-185, 189-191, 195-197

May, T, 1993, *Social Research: issues, methods and processes*, Open University Press, Buckingham, p.65-110, 133-151

Mays, N. & Pope, C. (1995). "Qualitative Research: Rigour and Qualitative Research." *British Medical Journal*. 311(6997), 109-112

McDermott E, Graham H, 2005, Resilient young mothering: Social inequalities, late modernity and the 'problem' of 'teenage' motherhood, Journal of Youth Studies, 8(1), 59-79

McDermott E, Graham H, Hamilton V, 2004, *Experiences of being a teenage mother in the UK: A report of a systematic review of qualitative studies*, Universities of Lancaster and Glasgow, pp.4-10, 27-39

McVeigh C, Smith M, 2000, A comparison of adult and teenage mother's self-esteem and satisfaction with social support, *Midwifery*, 16:269-276

Miller et al 1976, in O'Reilly P, 1988, Methodological issues in social support and social network research, *Social Science and Medicine*, 26; 8; p.863-873

Milne-Home J, Power A, Dennis B, 1996 *Pregnant Futures: barriers to employment, education & training amongst pregnant & parenting adolescents* (Canberra, Australian Government Publishing Service)

Minichiello V, Aroni R, Timewell E, Alexander L, 1990, *In-depth Interviewing: Researching People*, Longman, Cheshire, p.87-106, 283-321

Mitchell, J, 1969, The concept and use of social networks, eds. Mitchell J, *Social Networks in Urban Situations*, Manchester University Press, Manchester

Mitchell W, Green E, 2002,'I don't know what I'd do without our Mam' motherhood, identity and support networks, *The Sociological Review*, 50 (1), 1-22

Moffitt T, 2002, Teenaged mothers in contemporary Britain, *Journal of Child Psychology and Psychiatry*, 43 (6), pp.727-742

Morrow, V, 2000, 'Dirty looks' and 'trampy places' in young people's accounts of community and neighbourhood: implications for health inequalities, *Critical Public Health*, 10 (2), 141-152

Morse J, Barrett M, Mayan M, Olson K, Spiers J, 2002, Verification strategies for establishing reliability and validity in qualitative research, International Journal of Qualitative Methods, 1 (2)

Mulchrane P, 13 Year Old Boy Becomes Dad, The Mirror, 3/10/09

Nathanson, C, 1991, *Dangerous Passage: The social control of women's adolescence,* Philidelphia, PA: Temple University Press

Nightingale, D.J., Cromby, J., 1999, (Eds), *Social constructionist psychology: A critical analysis of theory and practice*, Buckingham: Open University Press

O'Reilly P, 1988, Methodological issues in social support and social network research, *Social Science and Medicine*, 26; 8; p.863-873

Oakley A, Rajan L, Turner H, 1998, Evaluating parent support initiatives: lessons from two case studies, *Health and Social Care in the Community*, 6(5): 318-330

Oakley, Hickey, Rigby, 1994, Love or money? Social support, class inequality and the health of women and children, *European journal of Public Health* 4:265-273

ONS, 2001, *Social Capital: A Review of the Literature*, Office for National Statistics

ONS, 2005, in Harden A, Brunton G, Fletcher A, Oakley A, Burchett H, Backhans M, 2006, *Young people pregnancy and social exclusion: a systematic synthesis of reserach evidence to identify effective, appropriate and promising approaches for prevention and support,* EPPI-Centre, Social Science Research Unit and Univeristy of London, Report March 2006

ONS, 2007, in Salford City Council, 2007, *Teenage Pregnancy in Salford*

Oxley et al 1977, in O'Reilly P, 1988, Methodological issues in social support and social network research, *Social Science and Medicine*, 26; 8; p.863-873

Passino A, Whitman T, Borkowski J, et al, 1993, Personal adjustment during pregnancy and adolescent parenting, *Adolescence*, 28 (109), pp.97-122

Pearlin et al 1981, in O'Reilly P, 1988, Methodological issues in social support and social network research, *Social Science and Medicine*, 26; 8; p.863-873

Penn H and Randall V, 2005, Childcare and Local Partnerships under Labour, *Journal of Social Policy*, 34(1), p.79-97

Phoenix A, 1993, The social construction of teenage motherhood: a black and white issue, in Lawson A and Rhodes D (eds) *The policies of pregnancy: Adoloescent sexuality and public policy*, London, Yale University Press

Phoenix A, 1991, Young Mothers?, Cambridge, Polity Press

Portes A, 1998, Social Capital: Its origins and applications in contemporary sociology, *Annual Review of Sociology*, 24, 1-24

Potter J, 1996, Discourse Analysis and Constructionist Approaches: Theoretical Background in John T.E. Richardson (Ed.),1996, *Handbook of qualitative research methods for psychology and the social sciences.* Leicester; BPS Books

Putnam, R, 1993, 'The prosperous community, social capital and public life' *American Prospect*, 4:13

Putnam, R, 1995, Bowling Alone: America's Declining Social Capital *Journal of Democracy* 6 (1) 65-78.

Putnam, R, 2000, *Bowling Alone - The Collapse and Revival of American Community* New York: Simon & Schuster.

Richards T and Richards L, 1994, From filing cabinet to computer, in Bryman A and Burgess G (Eds), 1994, *Analysing Qualitative Data*, Routledge, London

Richardson L and Le Grand J, 2002, Outsider and insider expertise: The response of residents of deprived neighbourhoods to an academic definition of social exclusion, *Social Policy and Administration*, 36(5), p.496-515

Ritchie & Spencer, 1994, in Qualitative data analysis for applied policy research, In Bryman A and Burgess R (eds) *Analysing Qualitative Data*,173–194 London, Routledge.

Room G, 1995 (eds) *Beyond the threshold: The measurement and analysis of socials exclusion*, Bristol, The Policy Press

Rose 1982, in Minichiello V, Aroni R, Timewell E, Alexander L, 1990. *In-depth Interviewing: Researching People*, Longman, Cheshire, p.87-106, 283-321

Rose D, & Sullivan, O, 1996, *Introducing data analysis for social scientists (2nd ed.),* Open University Press.

Sarason I, Johnson J, Siegal J, 1978, Assessing the impact of life changes: development of the life experiences survey. *Journal of Clinical and Consulting Psychology*; 46:933–946

Sherbourne C, Stewart A, 1991, The MOS Social Support Survey, *Social Science Medicine*, vol. 32, no. 6, p. 705-14

Shield J, Baum J, 1994, Children's consent to treatment, *British Medical Journal*, 308, p.1182-83

Silverman D, 2001, *Interpreting Qualitative Data: Methods for Analysing Talk, Text and Interaction*, Sage Publications, London, pp13, 18, 32-35, 64-68, 88, 89, 95-97, 111-112, 225-251

Sixsmith, J. Boneham, M. Goldring, J, 2001, The Relationship Between Social Capital, Health & Gender: A case Study of a Socially Deprived Community Health Development Agency, London.

Smith E, 17 Classmates in Pregnancy Pact, The Sun, 21/06/08

Smith G, Pell J, 2001, Teenage pregnancy and the risk of adverse perinatal outcomes associated with first and second births: population based retrospective cohort study, *British Medical Journal*, 323, downloaded from bmj.com 3/8/2005

Smith T, 1993, Influence of the socio-economic factors in attaining targets for reducing teenage pregnancies, *British Medical Journal*, 306, 1232-1235

Social Exclusion Unit, 1999, *Teenage Pregnancy Strategy*, June 1999, HMSO

Social Exclusion Unit, 2001, *Preventing social exclusion,* HMSO

Speak S, Cameron S, Woods R, Gilroy R, 1995, *Young single mothers: barriers to independent living*, Family Policy Studies Centre

Szreter S, 2005, *Health and Wealth: Studies in history and policy*, University of Rochester Press, pp.376-412

Szreter S, Woolcock, M, 2004, Health by association? Social capital, social theory, and the political economy of public health, *International Journal of Epidemiology*, 33, 650-667

Tesch R, 1991, Introduction. *Qualitative Sociology*, 14; 225-243.

Townsend P, 1979, *Poverty in the United Kingdom*, Hammondsworth, Penguin

Turner J, Grindstaff C, Philips N, 1990, Social support and outcome teenage pregnancy, *Journal of Health and Social Behaviour*, 31 (March): 43-57

Turner, R, 1983, Direct, indirect, and moderating effects of social support on psychological distress and assorted conditions. In H. Kaplan (Ed.), *Psychological stress: Trends in theory and research* , New York: Academic, p.105-155,

Walker A & Walker C (eds) 1997, *Britain divided: the growth of Social Exclusion in the 1980s & 1990s*, London CPAG

Walker, K., Macbride A., & Vachon, M, 1977, Social support networks and the crisis of bereavement. *Social Science and Medicine*, 11, 35-41

Warner, R, Appleby, L, Whitton, A, Faraghen, B, 1996, Demographic and obstetric risk factors for postnatal psychiatric morbidity, *British Journal of Psychiatry*, 168, 607-611 – Reference for EDPS

Walker, A. and Walker, C. (eds.)(1997), *Britain Divided: The Growth of Social Exclusion in the 1980s and 1990s*, London: Child Poverty Action Group

Wasoff F and Hill M, 2002, Family policy in Scotland, *Social Policy and Society*, 1(3), 171-182

Weaver and Atkinson, 1995, 'From Coding to Hypertext' in R. G. Burgess (ed.) *Computing and Qualitative Research: Studies in Qualitative Methodology 5.* Greenwich CT: JAI Press, pp. 141-168

Weiss, 1969 in Berkman L, 1984, Assessing the physical health effects of social networks and social support, *Annual Review of Public Health*, 5:413-32

Wellings K, Wadsworth J, Johnson A, 1996, *Teenage sexuality, fertility and life chances. A report prepared for the Department of Health using data from the National Survey of Sexual Attitudes and Lifestyles*

Whitehead M & Diderichsen F, 2001, Social Capital and Health: tiptoeing through the minefield of evidence, *The Lancet*, (358), 21; 165-166

Whitehead E, 2001, Teenage pregnancy: on the road to social death, International *Journal of Nursing Studies*, 38, 437-446

Whitehead M and Tones K, 1991, *Avoiding the Pitfalls*, London, Health Education Authority

Whyte, 1981 in Silverman D, 2001, *Interpreting Qualitative Data: Methods for Analysing Talk, Text and Interaction*, Sage Publications, London, pp13, 18, 32-35, 64-68, 88, 89, 95-97, 111-112, 225-251

Wilkinson R (eds), 1996, *Unhealthy Societies: The afflictions of inequality*, Routledge, London

Williams et al 1981, in O'Reilly P, 1988, Methodological issues in social support and social network research, *Social Science and Medicine*, 26; 8; p.863-873

Willig C, 2001, *Introducing Qualitative Research in Psychology: Adventures in theory and method*, Buckingham, Open University Press

Wilson H, Huntington A, 2005, Deviant (M)Others: The construction of teenage motherhood in contemporary discourse, *Journal of Social Policy*, 35 (1) 59-76

Wilson J, 1995, Maternity Policy, Caroline: a case study of a pregnant teenager, *Professional Care of Mother and Child*, 5(5), 139-142

Woolcock, M, 2001, The place of social capital in Understanding Social and Economic Outcomes. ISUMA *Canadian Journal of Policy Research* 2 (1) 11-17.

World Bank, 2000, *World Development report 2000/01: Attacking Poverty*, Oxford University Press, New York

Yin R, 2003, *Case Study Research and Design*, Sage, pp1-16, 24, 36-43